VOL. VIII. FEBRUARY, 1901 No. 2

BOSTON MEDICAL
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Georgia Journal OF Medicine and Surgery.

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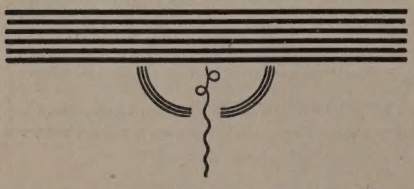

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ISSUED MONTHLY.

Vol. VIII. SAVANNAH, GEORGIA, FEBRUARY, 1, 1901. No. 2.

An era is fast approaching, when no writer will be read and appreciated by the great majority, save and except those who can effect that for bales of manuscript, that the hydrostatic screw performs for bales of Cotton by condensing that matter into a period that before occupied a page.—COLTON.

ORIGINAL COMMUNICATIONS.

A STUDY OF ARTIFICIAL INFANT FEEDING.

BY W. E. FITCH, M.D.,

Savannah, Ga.

The attempt to prepare by artificial means a good substitute for mother's milk is a subject on which, of late years, a vast amount of thought, scientific research and ingenuity have been expended. In seeking a substitute one naturally turns to domestic animals for the source of supply; cow's milk being usually selected because being plentiful it is easily obtained and cheap. There are many women who, no matter how willing, are completely unable to suckle their offspring, and a large number in whom the secretion of milk fails after a few weeks or months of lactation. These must resort to artificial feeding.

To ensure success in artificial feeding—always a difficult task—it is important to make a detailed study of the following questions:

(a) The selection of a proper substitute for the natural food—the breast milk.

(b) The quantity to be given; the method of preparation.

(c) The mode of administration, and (d) the means of preservation.

Owing to a series of causes incident to modern civilization artificial feeding is rapidly replacing mother's milk as a food,

The chief problem, therefore, in regard to the preparation of a satisfactory infant food is, how to best adapt it for intestinal digestion —for it must be remembered, that the stomach is not the organ most

concerned in the digestion of milk; according to Traube the stomach is only a temporary holder, complete digestion taking place in the small intestine.

COMPOSITION OF MOTHER'S MILK.

This question is a much more complicated one than has been thought. It has been presumed too much that all mother's milk confirmed to a definite standard. As a matter of fact, it is well known that a baby will thrive on one woman's milk and not on another's. According to Rotch of Boston the average human milk has the following analysis:

Reaction		slightly alkaline	
Spr. gr		1.030	
Water		87.88	
Total Solids.	Fats	3–4	1312
	Sugar	6–7	
	Proteids	1–2	
	Ash	0.1-01	

Monti, who in recent years has made a large series of analyses of mother's milk, says that its constitution is only more or less constant. We know that its composition varies from time to time during the day and even from minute to minute during a single nursing. It has been said that there is more albumin in woman's milk than in cow's milk, but it is doubtful whether all this albumin exists as casein. Pfeiffer says that all nitrogenous substances in milk exist in the form of casein, but this is not universally accepted. There are analyses of mother's milk that seem to show that it contains less albumin than that of cow's milk. There is no doubt that there is more phosphorus and less sulphur in mother's milk than in cow's milk. Besides the phosphorus exists in the shape of acids in salts which are not so easily precipitated from their solution in woman's milk and so are much more easy of absorption. Analyses vary as to the comparative amount of proteids and nuclein in different milks. It is agreed that the milk-curdling ferment forms larger curds from cow's milk than from woman's milk and this is an important element in their comparative digestibility. Nearly all the phosphorus in woman's milk exists in the shape of organic compounds, while in cow's milk the phosphorous salts occur as organic bodies rather difficult of assimilation, and hence it is that rachitis is so apt to develop in bottle-fed babies. The amount of iron in the two milks is about the same. There is less sodium in cow's milk, which shows the necessity for the addition of sodium chlorid for artificial feeding. The advisability of the addition of malt and cereals was noticed clinically by the writer after many failures in attempting to find a suitable food for infants.

COMPOSITION OF COW'S MILK.

Cow's milk, according to Rotch of Boston, has the following analysis:

Reaction	slightly acid
Spr. gr	1.032
Fat	4.04
Sugar	4.55
Proteids	4.15
Mineral matter	0.71
Total solids	13.45
Water	86.55

From the above analyses we see that milk contains sugar, fats and albuminoids, materials sometimes most difficult to digest—unaided. Malt, on account of its diastatic action, is here of the greatest service, combining with the pancreatic secretion in changing starch into glucose. In any infant food, starch, whether constituting a part or ingredient of, barley-water, flour, meal, etc., is usually present and is for important reasons practically in all artificial foods. The complete digestion of milk must be obtained, or the food fails to serve its purpose, and falls below the standard of proper usefulness.

MILK SUGAR.

Rotch's original suggestion for the modification of cow's milk included the addition of milk sugar in order to make up what was lacking in cow's milk as compared with woman's milk. There is some reason to doubt, however, whether the milk sugar in woman's milk is the same as that in cow's milk. The milk sugar obtained in the ordinary avenues of commerce is often impure. Besides, it is probable that there is not in any cow's milk enough milk sugar to accomplish the purposes that substance has in the food. Some of the sugar of milk is absorbed as galactose and glucose.

Lactose and maltose accomplishes a good purpose when infants are constipated. A slight increase of the amount usually added to the milk will obviate the necessity for the use of laxatives.

MALT AND CEREALS.

Illustrating the advisability for adding malt cereals and sodium chloride to cow's milk, I will briefly report a case which came under my observation some eight or ten months ago. The little 2-year old son of Mr. B. was brought to me with the following history: At birth he was a fine baby, eight-pounder, and grew nicely for the first few weeks, when the mother's milk failed to sustain the child. It became emaciated, had no appetite. The attending physician ordered the baby weaned and placed on condensed milk. The digestive organs being weak the milk was not digested; every stool contained lumps of casein; the child was fretful, irritable, and at the age of one year weighed only 20 pounds; its muscles were flabby, the joints large and prominent. From this time on till I was called the child was fed with all kinds of prepared foods, including cow's milk in various dilutions, boiled and raw. At the age of two years, when I first saw the boy, he was approaching a rachitic state,

the stomach was irritable, vomited nearly everything taken, enteritis was present, child passing quantities of casein (undigested lumps of milk). The child had never walked nor talked, and had only the incisor teeth, and was a helpless living skeleton. A few days before seeing this child I received two pound packages of "Wyeth's Prepared Food," which, according to analysis made by a competent chemist, is found to contain the following:

	Fat.	Albuminoids.	Sugar—Lactose and Maltose.	Sugar—Cane Sugar.	Gluten and Starch,	Ash. Phosphates, Chlor., etc.
Wyeth's Prepared Food..	2.76	16 90	38.	none	27	3.55

While so little fat as many of the prepared foods contain is insufficient, and there should be present in any infant's food from two to three per cent. of fat, as much as four per cent. is considered by the best authorities admissible, and when such a large percentage is desirable in any particular case, the addition of a tablespoonful of cream at each feeding will answer the purpose admirably. The 27 per cent. of glucose and starch in Wyeth's Prepared Food is made entirely of altered starch and gluten, and seeing an indication in this case for malt, milk and cereals, I gave the mother both packages of the food, with full instructions for its use, viz:

Wyeth's Prepared Food, 2 tablespoonfuls;
Warm water, 2 tablespoonfuls;
Milk, ½ pint;
Cream, 1 teaspoonful;
Sodium chloride (salt) 10 grains.

This amount every two or three hours, or as often as the child asked for food.

I of course looked after the enteritis which was present; first gave a mild mercurial, followed with tannopine in 8-grain doses, and had the the pleasure of seeing the little patient begin to improve after the first few days, which continued; the bowels resumed a natural condition, the stomach became quiet, the digestion improved, and after a few weeks the boy became strong, the balance of his teeth appeared, and now, after eight months on the food, he is well, a fat, rollicking boy, walks anywhere and talks enough for two boys, and now goes to the table and eats and digests ordinary table foods.

Since securing such pleasing results with this food I have continued to prescribe it whenever an artificial food was indicated.

MODIFIED MILK.

According to Dr. H. D. Chaplin, the great defect in percentage feeding is that no attention is paid to the difference in composition of cow's milk and breast milk. As before stated, the ingredients in the milk of various women, and even in the same woman at various times, differ very much. It is a question of experimenting until the most suitable food is found. Not all children will thrive on modified cow's milk, no matter how carefully their individual peculiarities are

studied. The milk should be gathered with the greatest possible care as to cleanliness and should be kept on ice from the time of its milking until ready to prepare for consumption. An ideal modification of cow's milk is a very knotty problem, but the author believes a milk to which has been added malt, cereals, table salt and cream will make an artificial food which will meet the demands in the greatest number of cases. This disposes of the argument that the addition of cereals is the addition of foreign matter; trouble from the starch can be easily overcome by dextrinizing the gruel, and the mechanical separation of the particles of coagulum make a milk diluted in this way much more digestible than milk diluted to the same extent with water. All of us have frequently seen very large tough curds passed even by breast-fed infants and more frequently by infants fed on cow's milk.

Where the density of the coagulum is dependent upon the proportion of caseinogen, by reducing the percentage of caseinogen present the coagulum will immediately become softer. Under such conditions I have found that the curd can be easily split up by adding such cereals as are found in Wyeth's Prepared Food.

Not infrequently we will be called to see a little patient who has a decided aversion to milk alone. In such cases the milk can be omitted for a few times, using water as a dilutent. It is not necessary to dispense with the milk altogether, but only for a few feedings. as milk is a valuable dilutent for the food, rendering it more palatable and adds to its nutritive value. When patients have previously used milk exclusively with unsatisfactory results, here the administration of the food will avoid the necessity of dispensing with milk entirely, as the food itself possesses sufficient digestive properties to thoroughly digest any milk that the patient may feel inclined to take. Cream may also be added at the discretion of the physician, after the food has been boiled with warm water alone, preferably just before each feeding. It is not necessary to cook the food at each feeding; night and morning will do, keeping it on ice and simply warming it for each separate feeding.

This food is not a predigested food, but is one that when prepared for use immediately exerts upon itself that power of digestion which has been carefully preserved in its constituents. The malt rich in diastase, acting in conjunction with the pancreatic secretions, digests the fats and albuminoids of the milk, converting the starch of the cereals into sugar (maltose) and neutralizing the tendency of the acids of the stomach to form curds, thus rendering the food of infinite value to the infant, supplying the necessary nutrition and material to strengthen and build up the human economy, at the same time relieving the stomach of the infant from the expenditure of energy necessary to the digestion of ordinary food.

FATS AND STARCHES.

When prepared warm or boiled with milk or water, the natural digestive principles in the food at once become active, the casein of

the milk being so modified as to preclude the formation in the stomach of firm indigestible curds, and the farinaceous elements of the food are rendered soluble, which is a most important result and is not attained by any other food.

Fats are added to cow's milk by some because of their value for nutrition and also because they seem to add to the digestibility of the casein in cow's milk. With regard to the use of starches a revolution of opinion has occurred in recent years. The addition of a certain amount of cereals to the infant's food is now acknowledged by practically all the authorities on children's diseases as a useful procedure. This use of cereals has been the practice and teaching of Dr. Jacobi for more than a quarter of a century. The old contention that the infant had no diastase for the conversion of starch into sugar is no longer considered to be true. Heubner, of Berlin, showed that diastase can be found in the parotid gland of the infant two hours old, sixteen days old, and two months old. An infusion of parotid gland converts starch into sugar from the beginning of life. An infusion of pancreatic gland does not convert starch into sugar, and its diastasic power even at the end of a year is but feeble. The objections in the old literature of pediatrics to the use of starch in infant feeding referred to the excessive use or the exclusive use of starchy food. Where cow's milk is diluted with some cereal according to the author's method the feces contain no fat and but very little starch.

It is evident, then, that cow's milk must form the basis of any food for infant's use and no artificial food without cow's milk can be expected to prove suitable, as stated above, to which has been added malt cereals. Table salt and cream will make an artificial food which will meet the demand in a great number of cases.

HYSTERIA, ITS NATURE AND ETIOLOGY.

By HENRY BROOKS, Jr., M.D.
Assistant House Surgeon Plant System Hospital,
Waycross, Ga.

From the early days of Hypocrates, hysteria has been recognized, but not until the elaborate investigations of the illustrious Charcot, who, by his profound learning and analytical mind, has placed hysteria upon a firm clinical basis. Hysteria is without doubt the most puzzling of nervous diseases that the physician has to encounter. Hysteria has been classed as a functional disorder, but I am of the opinion that profound cases of hysteria, in which the symptoms are so persistent, the general health so impaired, the anæsthesias, paralysis and convulsions so pronounced, are caused by some organic lesion, and that future researches will abandon the idea that this disease is of a purely functional character. Distressing railway accidents furnish quite a number of cases of this class. The flying of

timber, the escaping steam, and the groaning of individuals, so impresses itself upon passengers injured in wrecks that hysterical symptoms may develop weeks, months or years later. Litigation also exerts itself to a great extent in the production of this trouble. Generally, in injuries from railroad accidents, the patient at once desires compensation. The constant solicitation of lawyers, who are very desirous of obtaining cases, the repeated examinations by medical attendants are liable to aggravate symptoms and render the condition decidedly worse. Although it is true we sometimes see cases of simulation and fraud, the greater majority of cases are due to a distinct lesion. Injuries that are considered trifling at the time of accident may develop later on nervous manifestations of a severe character. Syphilis is a great predisposing cause; it is probable that in syphilis a poison is produced which causes definite pathological changes. The presence of syphilis is of paramount importance, and it should be regarded a prime factor as a causative agent of hysteria. So also alcoholism, cocaine, morphine, tobacco, by the production of certain toxæmias, furnishes a sufficient base for traumatic neurosis to develop. Heredity is also an important feature to be considered, for phthysis, epilepsy, hysteria and persistent headaches may bring about a poor endowment of the nervous system of the child so that hysterical symptoms are liable to develop. Anything causing great mental or moral strain, such as severe fright, receipt of bad news, love affairs, are capable of causing this condition. Bailey says that meteorological disturbances, and especially lightning, are frequently the cause of nervous manifestations in persons of neurotic temperament, and sometimes seem to be the only etiological factor for well-marked neuroses, and he also adds that the person, who, after lightning stroke, develops any of the traumatic neuroses, in which hysteria is the most frequent, bears no trace of physical injury and probably has not been struck at all. It has been observed that protracted meetings of a religious nature have been followed by epidemics of hysteria. There is now a concensus of opinion that truma may produce organic lesions without injuring the spine or skull. Organic lesions and functional symptoms are sometimes found associated. In the majority of cases anæsthesias of a pronounced type are observed, the anæsthesia, which is generally found on the left side of the body, corresponding to the median line, and is rarely induced by suggestion, the skin mucous membrane and deeper structures are insensitive to pain, and it is a notable fact that the patient is ignorant of this condition. The special senses may be perverted or abolished, such as taste, smell, hearing and seeing. Anæsthesia is persistent and may last for months or years. Hyperæsthesias are frequently observed, and neuralgic pains of an agonizing character are generally noted; a blow directed to the arm will cause excruciating pain in the part by fixing the patient's attention; so also the constant solicitation of the physician and friends, sensitive parts are found in anæsthetic areas, and they are usually sup-

pressed by suggestion. Sometimes after an accident when there is time for meditation, or auto-suggestion, as defined by Charcot, contractures and paralyses of an obstinate nature occur. Hysterical palses generally terminate in recovery or may last for years. The hysterical hemiplegia, usually found on the left side, the left foot is dragged limply along the ground and the advance is made by the sound one. The confused mental state of hysteria is peculiarly interesting. Hysterical patients love to resort to extraordinary measures. One of Eversman's patients produced blisters on parts of body so that they may resemble trophic lesions. Careful investigation determined the fact that a piece of cloth covered with salve was found in patient's pocket-book and removed secretly, the formation of vescicles at once ceased. In hysterical subjects there is usually a loss of will power, lack of concentration and complete forgetfulness, which causes contradictory statements, so that hysterical subjects have gained reputations of being notorious liars. Patients suffering from hysteria lack determination and are very impulsive. Convulsions that are observed in hysteria resemble the convulsions of epilepsy. Preceding the attack patients are restless, are unusually talkative and quarrelsome; as a rule, the attack is usually preceded by an aura, as a painful feeling in abdomen which gradually rises until it reaches the throat; the face, which was at first pale, becomes intensely congested, vertigo presents itself and the patient becomes suddenly unconscious. These attacks are aggravated by emotional disturbances. Passage of urine very rarely occurs and the tongue is rarely bitten. Beating of the bed suspended respiration, various contortions, extensions, flexions of the body occur, violent outcries of rage or fear, the patient tears bed clothing and puts forth his greatest strength against those endeavoring to control him. Delirium of a peculiar nature is observed—disagreeable sights and animals are noted in his hallucination. The delirium may be marked by sadness and the patient bursts into sobs or tears, or it may assume a furious character. A previous history of hysteria, active pupils and a neurotic taint may greatly assist us in arriving at correct conclusions. Sanders cites cases, showing the difficulty at arriving at a correct diagnosis. He mentions two cases, both resembling intra-abdominal disease; in the first case, symptoms of intestinal obstruction; second case, peritonitis from perforation. There were present marked tympanitis, variation of pulse, vomiting, fever, pain in iliocæcal region; one patient operated upon twice and the other four times within year. No sufficient cause was discoverable to account for the symptoms. Toms reports cases of hemorrhage occurring from mucous membranes never subcutaneous, and as much as a pint of blood in quantity came apparently from the throat, stomach and ears. It has been determined that anæsthesias of cerebal origin are not as intense as hysterical.

The following case to my mind is of unusual interest, as it represents traumatic hysteria in all its stages, represents its relapsing

form, the persistence of symptoms and the alcoholic habit: On the night of June 25th, I received a telegraphic message that E. P. P., age 29, had been struck by lightning, and was asked to meet him. At 9 o'clock this man was brought to my office, and the following history was obtained: He said, "I was on top of cupola of caboose, and, when train was stopping, I caught hold of hand rail, at the same time lightning struck my side." I asked him what part pained him, and he stated that he was suffering from excruciating pain around his heart. Upon examination I discovered hemianæsthesia of left side, complete paralysis of left arm and slight paralysis of left leg. Patient was entirely ignorant of his anæsthesia, sticking needles deep in skin from forehead to toes did not cause pain, and there was absence of bleeding upon pricking.

This hemianæsthesia was complete; the left arm hung limply to his side, and was icy cold; erythema or pectoral muscles, faint red tracing following radial artery. I at once advised patient to remain a few days, but he stated that he was very desirous of continuing his work, and that he would call next morning, and he proceeded to engine with little assistance and mounted same. In about half an hour I received another message that E. P. P. was seriously ill and was again asked to see him. He arrived at hospital semi-unconscious, and when rational complained greatly of cardiac pains, heart's action irregular, no organic lesion of heart detected, temperature 99 3-5, pulse 120 irregular. He said that before coming to hospital he had several fainting spells, as he characterized them, and he seemed very much worried over the fact, as he stated that only women should be allowed this privilege. He stated that his heart felt as if it was being twisted in a vice. In about half an hour patient began having convulsions. These convulsions were hystero-epileptic in nature, lasting from two to three minutes. There was marked opisthotonos, congestion around forehead and neck, grinding of teeth, beating of hands against bed. The convulsions were ushered in by a distinct aura; patient was very talkative, unusually intelligent; as he was speaking to me, he would clasp his hands to his heart, and it would appear that in a moment of suffering almost approaching frenzy; this would be a distinct signal for a convulsion; passage of urine and fæces did not occur during attacks. These convulsions occurred about every twenty minutes, and during attack it was necessary to restrain patient to bed; the face muscles seemed to be the first ones affected, then respiratory-abdominal down to the legs, marked tremor of abdominal muscles; at expiration of each convulsion, patient was bathed in a cold, clammy perspiration. Upon more careful examination, hemianæsthesia left side of body corresponding to median line anteriorly from forehead to tip of toes, posteriorly from occiput to oscalcis, left arm lay lifeless to side, hyperanæsthetic spot, about as big as a dollar, situated over trochanter major. After he went to bed, complete hemiplegia of left side of body was noted, patellar reflex preserved, loss of smell, hearing and

taste on affected side; color blindness marked, unable to distinguish between red and green, violet and blue. On June 25th and 26th, paralysis in leg improving; on 27th, patient able to bend elbow and move fingers; on the 25th and 26th, he had between six and eight convulsions, which were of a mild character, pain around heart did not diminish in severity; on the 28th, no convulsion, pain in percardial region less severe; on the 29th, patient had marked hallucination, such as "John, hitch up the buggy;" marked delirium in which he would see various objects. Suddenly he developed an uncontrolable desire to travel, and against my advice he left the hospital, and at various points on the road he would telegraph me his condition; in about a week he returned to hospital feeling fairly well and took great delight in amusing the patients by sticking a long needle through the muscles of his arms and cheeks; his mental state was disordered and his statements were of a contradictory nature. He was taken with severe vomiting and went to bed. This condition was uninfluenced by medicine; loss of appetite, loss of weight, impaired digestion, persistent hiccoughs. In about ten days his condition improved and he again left the hospital. At this time hemianæsthesia was still pronounced during sleep, and during slight chloroform narcosis this condition would disappear to again return; muscles on affected side respond to galvanic electricity, which causes severe pain. Four months later this man came to the General Hospital at Waycross, and, assisted by Dr. C. R. Oglesby, Chief Surgeon, we made a careful examination. Complete hemianæsthesia of left side of body, color blindness, loss of taste, smell and hearing on affected side, pulse 80, pressure over spine caused pulse to increase to 120, again returning normal at the end of the examination, flushed face, tremor of various museles of body, quickened respiration; patient became so weak and hysterical that examination was postponed. His general condition had somewhat improved since his first disability at the Santord Hospital. When he walked he would drag his left foot as though it was a foreign body. We desired to keep him at the Hospital a few days for more extended observation, but he insisted upon leaving.

ROTARY LATERAL CURVATURE OF THE SPINE.

By DR. DANIEL W. MARSTON,

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With the possible exception of the treatment of appendicitis, there is probably not in all medical literature any topic on which our profession has, at intervals of time, held as many different and diametrically opposed opinions as has been the case with rotary lateral curvature of the spine.

Within the memory of men yet young, certain members of the profession in this country, as well as across the water, have claimed

it to be possible to cure cases of lateral curvature of the spine after extensive bone changes had taken place.

It is scarcely necessary for me to say here that these views are not now endorsed by representative surgeons. New ideas, however, even when sustained by unlimited pathological and bacteriological research and clinical experience are often slow of adoption, and it is on this account that I propose to go over briefly, not only the etiology and pathology, but also the treatment of this serious condition.

Rotary lateral curvature differs from tuberculosis of the spine. It is never produced by inflammation or disease of the spinal column.

The etiology of those curves occurring high in the vertebræ column either in the dorsal or cervical region is, I believe, nearly always congenital or rachitic.

A rapidly growing child, who sits in a faulty attitude, or stands in such a position as to constantly curve the spine, will often develop rotary lateral curvature.

Curves that occur in the lumbar region are usually due to such a cause as this, or to a shortened limb or tilted pelvis. Paralysis of certain muscles may also be an important factor in the etiology of these deformities. I have known cases where great deformity resulted from the intercostal adhesions following the absorption of a pleuritic effusion. Deformity of this kind is seen in the dorsal vertebræ, for the reason that the spine bends where there is a change in the ribs and in the muscles between the ribs.

The deformity in lateral curvature is produced by absorption of the vertebra from pressure. As the spine bends, rotation always takes place in the direction of curves. Then we say that nearly all cases of lateral curvature are to be considered as cases of lateral rotary spinal curvature. When more than one curve occurs, it is then called double lateral rotary spinal curvature. One of the most common symptoms of lateral curvature is the projecting shoulder-blade and the drooping shoulder. These are cases that find their way to various bandagers, who adjust worthless appliances, and the apprehensions of the mother are put at ease by such charlatans until after a year or two, when the orthopedist is consulted, he finds an incurable curve in the vertebra produced by absorption. Then the projecting shoulder-blade, the drooping shoulder, the prominence of the ribs on one side of the vertebra—as the patient is bent forward—the absence of pain and spasm of the muscles, the general good health of the patient, are symptomatic of curvature.

Bone Changes.—On one side the bodies of the vertebral become absorbed by pressure, but on the opposite side they are normal. There is not a single straight spine in the world. If there were the person would break his head every time he jumped six feet. Every lateral curvature, to be cured, must have compensating curves so as to allow a vertical line to fall though the center of the curves and to fall inside of the base formed by the feet. In some lateral curva-

tures, as in rickets, the deformity is due to pressure. Ossification, as in the ossified man, is produced by central nerve lesions.

Treatment must be based on rational principles. I would treat lateral curvature with gymnastics and a support to relieve pressure; and Pott's disease by fixation to give nature a chance to repair.

Lateral Curvature.—Some orthopedists say every brace produces atrophy. Others that bracing is all that is required to remove pressure and prevent absorption. Bracing properly done does not produce absorption. I know of a gymnastic professor who relieved one patient and made an athlete of him. Of course, the curvature still remains. It is a very good plan to always determine the extent of bone changes before beginning treatment. Bending forward shows it. A straight line along the back demonstrates the extent of deviation. The diameter of the vertebral column is two inches. If a displacement of one-half of this occurs to either side, there is unstable equilibrium and exercise cannot correct.

The treatment is extension and immobilization of the spine. Nothing does this as well as plaster of paris jacket. The spinal supports made of wood, leather, wire, paper, celluloid, etc., are worthless. In my private practice and in my hospital work I advocate the jackets made of plaster of Paris. To make a good jacket or corset, good materials must be used. In addition to these, as Dr. Phelps has so truthfully and forcefully stated, the whole appliance is worthless "unless the plaster is mixed with a proper amount of gray cerebral matter." In the absence of the latter it is worthless. Proper materials must be used, else the plaster will not set rapidly. H. B. Claflin & Co. make a perfect hospital crinoline, containing just the proper amount of sizing and no indigo. The White Dental Manufacturing Company, of New York, puts up the plaster in tin cans, hot from the oven. These two materials make, when put together properly, a perfect bandage, that will set in five minutes. This rapid setting of the plaster is necessary, because the hand holds it to the corrected position of the deformity. This material, with the stockinet sold by Ford, completes the materials necessary to make a perfect corset. The crinoline costs six cents a yard, the plaster of paris three cents a pound, and the stockinet thirty cents a yard. All of the arguments which have ever been advanced against the use of the corset amount to nothing in the presence of an established fact. You will observe that this child with lateral curvature, after the corset is adjusted, is two and a half inches taller than without the corset. If anybody can explain to me what makes this child taller, outside the support he is given by the corset, I will concede that the corset does not support. Until this question is answered I will continue to believe that the arguments advanced against the support of the corset are all fallacious. (304 W. 116 street).

THE DIAGNOSIS OF ECTOPIC PREGNANCY BEFORE RUPTURE, BASED ON ELEVEN CASES.*

By J. F. BALDWIN, A.M., M.D.,

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"No authentic description exists of an unruptured tube-pregnancy" (Lawson Tait, "Diseases of Women," 1889, page 451). "I defy anybody to have diagnosed such a case beforehand, for the woman had not even missed a period" (Ibid., page 452).

Our real working knowledge of extrauterine pregnancy dates back only about twenty-five years. Previous to that time deaths were reported from so-called accidental hemorrhage into the peritoneum, and also deaths from intraperitoneal and extraperitoneal hematocele. Many cases had been reported of fetuses found in the abdominal cavity and of lithopedions found many years after the pregnancy from which they dated their origin, but it was not until twenty-five years ago that from a careful study of these cases, and as the outgrowth of these late diagnoses, data were arrived at from which we derived accurate knowledge of the pathology of ectopic gestation.

While, a few years ago, the rank and file of the profession could not but regard as extraordinary the diagnostic acumen of the men who could make the diagnosis of tubal pregnancy on the occurrence of rupture, at the present time, with the increase of literature on this subject and our better knowledge of its symptomatology, intelligent physicians everywhere expect uniformity to make a correct diagnosis on such occurrence. The sharp, colicky pains, the syncope and the collapse, at once attract attention and point almost unerringly to the diagnosis. But a diagnosis deferred until rupture has occurred necessarily results, in a large proportion of cases, in being but the mere preliminary to a fatal termination. The patient may be far removed from surgical assistance, and death may occur long before such assistance can be obtained.

With our present knowledge on this subject, I believe it is now possible, in a fairly large proportion of cases, to make a diagnosis of tubal pregnancy before the occurrence of rupture. This statement, I know, is in direct contradiction to statements made by Mr. Lawson Tait in his published writings of 1888 and 1889; but the profession at large knows much more of ectopic pregnancy now than it did ten years ago, when Mr. Tait reported that he had seen but one case of ectopic pregnancy before the period of rupture, and in that did not make the diagnosis at the time of the examination, but found the ruptured cyst three days later at the operation, which had been made imperative on account of the supervention of alarming symptoms.

It is true that in many cases of tubal pregnancy no symptoms occur which lead the woman to suspect that anything is wrong, least

* Read before the American Association of Obstetricians and Gynecologists, at Louisville, September 18-20, 1900.

of all to consult a physician, until the occurrence of alarming symptoms due to rupture and the resulting hemorrhage. Nevertheless there are unquestionably very many cases in which symptoms do arise, and in which a physician is consulted, and in which a presumptive working diagnosis is clearly possible.

There are no pathognomonic symptoms of tubal pregnancy or of any other form of ectopic pregnancy. Usually, however, we find the following points: The patient gives a history of several years of sterility (many exceptions); she has missed a menstrual period, perhaps two of them (numerous exceptions); she has noticed some unusual pains in the pelvis, which she will probably describe as boring, griping, or colicky in character, these pains being situated usually in the region of an ovary; she has perhaps, within a few days of the time of consulting her physician, had a more or less irregular hemorrhage; perhaps has discharged pieces of membrane which she supposed indicated an abortion, and consults her physician with the idea that such is the case, owing to the hemorrhage and the pain and the suspicion of an existing pregnancy. Possibly, however, there has been no suspicion of a pregnancy, as the woman has accepted her sterility as incurable and has dismissed from her mind such a possibility.

On making a vaginal examination, if the conditions are at all favorable the examiner will find upon one side or the other of the uterus, or back of it, a fusiform, quite well-defined cystic tumor of about the size of a pullet's egg or a little larger. This tumor will probably be quite tender on pressure, will be quite symmetrical in outline, and will usually be distinctly pulsating. When such a tumor is found in a woman in whom we have reasonable grounds to suspect a pregnancy; when the uterus at the same time is found somewhat enlarged and having the feel of pregnancy, but not enlarged as much as we would expect in a pregnancy of so long continuance as the history indicates, a presumptive diagnosis of tubal pregnancy is warranted, and the matter of an operation should be carefully and without delay considered.

There are a few conditions which give us the same kind of a tumor as is found in these cases. These conditions, however, are seldom accompanied by the other symptoms which have been enumerated, and are in themselves such as to warrant, if not to demand, operative intervention. As enlarged and adherent ovary in Douglas' cul-de-sac cannot, perhaps, be differentiated from a tubal pregnancy in the same location. An old pyosalpinx, a hydrosalpinx, a small cyst of the broad ligament, or an enlarged ovary in its normal location might be mistaken for an unruptured tubal pregnancy. It is not likely, however, that any of these conditions would be accompanied by symptoms pointing to an ectopic pregnancy, and yet they may; but all these conditions are such as to justify operative interference. If the operator, suspecting a tubal pregnancy, finds a pus tube, as I have twice done, or a cystic ovary, he has certainly bene-

fited his patient by their removal; while if he finds an unruptured tubal pregnancy he has, by a very safe operation, saved his patient from the gravest of dangers. In other words, he has performed an operation the mortality of which in experienced hands is almost nil; while the mortality of ruptured tubal pregnancy, while necessarily unknown, is certainly frightful.

In order to render the early diagnosis of ectopic pregnancy possible, it is necessary for physicians to learn to suspect it and to examine with that suspicion in mind. The physician who, without making any examination, tells all middle-aged women who come to him complaining of irregular hemorrhages that they are merely having the change of life, will not likely make an early diagnosis of cancer of the uterus, and he will probably tell patients who come to him with symptoms of ectopic pregnancy that they are merely threatened with a miscarriage. He will make no further investigation, and will hence uniformly fail to make a diagnosis. The physician, however, who, having in mind the possibility of an ectopic pregnancy, thoroughly examines all patients whose history and symptoms point to this condition, will, in a large proportion of cases, make a correct diagnosis and by prompt intervention will achieve a signal triumph for himself and his profession.

Menstruation.—One menstrual period, perhaps two, has ordinarily, but not always, been missed, or the last menstruation was in some particular irregular. There has occurred, perhaps, a dribbling of blood, but not a normal flow. There may have been a discharge of clots, or possibly a decidual membrane resembling the membrane passed in an early miscarriage. If such membrane can be obtained, microscopical examination showing the absence of chorionic villi would render a diagnosis positive; but these membranes have usually been destroyed.

Sterility.—Not too much stress should be placed upon the previous sterility of the patient. This should be taken into account in a summary of the symptoms, but it is not of much moment, since in many cases there has been no such previous history.

Pain.—The pain of tubal pregnancy is usually sharp and colicky in character and quite distinctly localized on one side, or it is of a dull, boring, constant character—a steady, severe ache. The pain in the one case is due to the internal stretching, with slight giving way, of the peritoneal investment of the tumor. In the other, the pain is due to the constant tension of the tumor walls, but without as yet any local yielding. The sharp, colicky pain is therefore very apt to succeed the other in point of time. The pain may be very severe, so severe as to result in some acceleration of the pulse during its continuance, but there is no elevation of temperature. Possibly the pain may be so severe as to result in fainting, but faintness is rather a symptom of at least partial rupture with some hemorrhage.

A woman who consults her physician presenting these symptoms, or several of them, should be at once carefully examined with the idea in mind of a possible tubal pregnancy. If that examination reveals a tumor such as has been previously described, the presumptive diagnosis of tubal pregnancy should be made and an operation unhesitatingly advised. The remote possibility of a mistake in diagnosis should be explained to the patient or her friends, but there should be no hesitation in urging an immediate operation. A slip, misstep, any sudden alarm even, may in a moment precipitate rupture, with all its unfortunate consequences.

At the Atlanta meeting of the American Medical Association (1896), in a discussion on this subject in the section of Diseases of Women, I reported five cases in which I had made the diagnosis and had operated on tubal pregnancy before rupture. (Two of these cases occurred in the same patient at an interval of eight months.) I believe I was the only one present who had ever made such diagnosis and had so operated. Since that time, however, a number of such operations have been made, and I think there can be no doubt that the time has come when such cases will be reported with increasing frequency until the diagnosis in suitable cases becomes recognized as an essential duty of the well-qualified practitioner.

This preliminary presumptive diagnosis must be made by the family physician. It will later be verified by the surgeon, but the early diagnosis of ectopic pregnancy, like the early diagnosis of uterine cancer and of appendicitis, must depend upon the education of the family physician.

The following six cases have occurred since the five which I reported in 1896:

Case 6—April 24, 1898, Mrs. S., age 22; married two years; never pregnant; menstruation always regular. Menstruation came on at the usual time five weeks ago, but came on and has continued up to the present time merely as a dribbling of blood. Has always enjoyed excellent health. Knows of no reason for not becoming pregnant. Has been having a feeling of weight and bearing-down in the pelvis, with a constant aching sensation which she locates in the womb. Vaginal examination shows the uterus somewhat enlarged and pushed forward toward the pubes by a mass in Douglas' cul-de-sac. This elastic, smooth in outline, somewhat tender, but without general pulsation. As there has been no history of any trouble prior to the last menstrual epoch, the probability of a tubal pregnancy seemed great, and an exploration through Douglas' cul-de-sac was advised. This was made two days later, and revealed a greatly distended tube without rupture, but with some free blood in the cul-de-sac, the hemorrhage having come from the open end of the tube. The specimen removed revealed a pregnancy estimated at about six weeks' duration.

Case 7.—December 8, 1898, Miss McD., age 24, servant. Had one miscarriage at three months two years ago; no other pregnan-

cies. Has not been entirely well since the miscarriage. Denies having had any pelvic disease; no dyspareunia. Was unwell regularly and normally two and one-half weeks ago. Complains of pain and bearing-down in the pelvis and back. Pains somewhat like labor pains came on just before nausea. Has had no intercourse since menstruation. Vaginal examination shows a very tender mass back of the uterus the size of a pullet's egg. This mass is excessively tender. She is positive that this tenderness has existed but for a very short time. Pulsation is distinct. The right ovary can be outlined; the left ovary also, but very indistinctly. The diagnosis seems to lie between a pus tube, which her history negatives, and a tubal pregnancy. Operation through the vagina Dec. 10. The right tube was found in Douglas' cul-de-sac, being held there by light adhesions. It was removed without difficulty and the entire specimen turned over to the pathologist for examination. He reported later that the specimen was that of a very early tubal pregnancy. Impregnation in this case probably took place just before her last menstruation. (Saw a moribund case, some years ago, in which fatal rupture of a tube pregnancy had occurred in a prolific multipara three weeks after the cessation of a perfectly normal and regular menstruation, and without the slighest suspicion of a possible pregnancy in the mind of the patient.)

Case 8.—May 5, 1899, Mrs. K., age 24; married four years; had a miscarriage during the first year of married life; no pregnancies since. Menstruated naturally, commencing on the 10th of March. Had always been very regular, and expected to menstruate April 18. The flow did not come on, however, until the 28th; continued for about five days, then stopped one day, then recommenced, and has continued as a mere show up to the present time. During this time she has had more or less pain in the right side of the pelvis. This pain was described as "cramping" in character. Has never had the slightest irregularity in menstruation before. Examination shows the uterus retroverted and adherent. Back of it and low down is a tender, cystic mass, the size of a small hen's egg. This is also adherent. She is sure that this tenderness could not have been there but a very short time. Diagnosis of a tubal pregnancy was made and an operation advised and made the next day per vaginam. The tube above the sac was ligated with catgut and the sac easily removed. Examination of the specimen verified the diagnosis.

Case 9.—August 22, 1899, Mrs. S., age 37; mother of five children, the youngest 3 years of age; was unwell from the 20th to the 25th of June; has had no show since. Several times during the last few weeks has experienced cramping sensations in the abdomen, more marked on the left side. Four days ago was taken with severe pain in the lower abdomen and sent for Dr. Mayhugh, her physician. He found a tender mass on the left of the uterus, the exact character of which he did not understand, but which led him to suspect ectopic pregnancy. Pain still continues, but is less severe.

On examination I found a well-defined mass to the left of the uterus, the uterus itself pushed over to the right. Could not detect pulsation. From the character of the mass and the history, concur in the previous diagnosis of ectopic pregnancy and advise immediate operation, which was made the next day. On opening the vault of the vagina, found some blood which had extruded from the open end of the Fallopian tube. The tube itself was distended to the point of bursting by the embryonic mass. In drawing the tube down into the vagina to effect its removal it was torn off near the horn of the uterus. The hemorrhage following the tearing was not very great, but it seemed best to secure its effectual control by opening the abdomen. This was done and the operation completed without any difficulty. Examination of the tumor revealed placental tissue and a very minute embryo. (This patient became pregnant normally in October and was safely delivered at full term).

Case 10.—March 27, 1800, Mrs. S., age 30; mother of four children, youngest 2 years of age; no miscarriage; no history of any pelvic disease. Should have menstruated ten days ago, but had merely a show at that time. It came on freely, however, a week later, and there is still some dribbling; no clots. Commenced having pain in pelvis a week ago, but had severe pain in the right side of the pelvis and epigastrium two weeks ago. Still has pain in the right side; this spot is "sore.' Has never had any such disturbance as this before. On examination, find a tender, pulsating mass just back of the uterus and to the right, continuous with the uterus; is very tender; pulsates indistinctly; about the size of a hen's egg. Diagnosis of tubal pregnancy seemed plain. Operation, made the next day, showed an ectopic pregnancy in the right tube, which was in Douglas' cul-de-sac and adherent. While breaking up the adhesions the sac ruptured, and the embryo was lost in the moderate hemorrhage which followed. Microscopical examination confirmed the diagnosis.

Case 11.—May 19, 1900, Mrs. W., age 26, mother of one child; age 3 years; no miscarriages. Patient had always menstruated regularly and normally, the last time being March 1. Some time after this menstruation she commenced having pains in the pelvis, especially on the right side. These have persisted until the present time, but have been much worse of late. She consulted her family physician, Dr. Dixon, some two weeks ago, and he at once suspected the possibility of an ectopic pregnancy. She declined an examination and passed from observation. Yesterday and last night she suffered with intense pain, and he was again called. On examination he found a condition of affairs confirmatory of his previous suspicions. Her pulse is good, but she complains of feeling short of breath and of pains resembling those of angina pectoris. Patient is quite fleshy, with thick abdominal walls; nevertheless an indistinct mass can be made out on the right of the womb. This is quite tender, but without any distinct pulsation. There was no tenderness

in this region previous to this sickness. Advise that patient be prepared for an operation, an anesthetic be given, and, if examination confirm the suspicion of ectopic pregnancy, an immediate operation be made. The patient was at once transferred to the hospital and this procedure carried out. The examination under the anesthetic abundantly confirmed the previous suspicion. As the mass was higher up than usual in the pelvis, the operation was made by the suprapubic route. Some blood had escaped from the fimbriated extremity of the tube, but the tube itself had not ruptured. Examination of the specimen verified the correctness of the diagnosis.*

EXTENSIVE SKULL FRACTURE WITH RECOVERY.

By A. J. RICHTER, M.D.,
Pine Bluff, Ark.

About midnight, October 20, 1900, I was called to attend a negro, Mose M., aged 26, who had just been taken from a saloon melee, after having been struck on the head with the handle of a billiard cue. The cue had been used as a javelin, and the full force of the blow had been received on the left parietal bone about three inches above, and one inch anterior to, the external auditory meatus. The man showed no knowledge of his environment, except that he would utter a low grunt upon being touched or loudly spoken to. The skin was not broken where he had been struck, and nothing could be palpated on account of an extensive hematoma that had already formed when I saw him.

Immediately cutting down and evacuating the blood tumor, an extensive fracture was felt. I tamponed the wound, and having shaved the head, applied a wet boracic acid dressing, and put him to bed, expecting to operate the next day. But the family objected, and it was only after several consultations that finally, Oct. 24th, consent was obtained. In the meantime the patient had regained consciousness at intervals of six or eight hours, for an hour or so at a time. There was complete paralysis of the right arm and absolute aphasia.

Oct. 23d the man had an epileptic seizure, followed in a few hours by another. These continued, increasing in frequency, so that on the morning of the operation he had seizures every fifteen minutes, and in the intervals the right side of his body jerked ceaselessly.

About 10 o'clock on the morning of the 24th I began the operation, Dr. A. B. Loving giving the anesthetic. Chloroform was used. An incision, horseshoe in shape, was made through my former incision, and the flap being turned back, a large comminuted fracture was revealed; there was a large central depressed hole, from which radiated numerous fissures of varying length. The depressed fragments were carefully removed. Partially broken fragments were wholly detached and removed. A large collection of coagulated blood was

sponged away. There was no hemorrhage of importance. I then replaced several of the larger pieces of bone, after uniting as much of the dura as possible. A gauze drain was left, the skin wound closed, and a dressing applied. Two hypodermics of strychnia were given, one-thirtieth gr. each, after the operation, and the man put to bed.

The next day part of the drainage was removed. The patient was semi-conscious. On the third day the rest of the drainage was removed, and the wound again packed with gauze. There had been no temperature, except in the evening of the second day, when he had 100.6° F. Since then it had remained at from 98.6° to 99° F. He had fully regained consciousness on the evening of the second day. He had two epileptiform seizures in the afternoon following the operation, since then none. He regained full use of his right arm, but remained unable to speak. On the eighth day the stitches were removed, and he could indistinctly articulate some words. He was given strychnia, one-sixtieth gr., four times daily.

November 12th he walked to my office from his house, a distance of about three-quarters of a mile. His articulation was much improved.

I saw him December 26th last, when he had entirely recovered his speech. His right arm was entirely normal, and he had never had any more epileptic seizures. He was doing heavy work in a lumber mill, and was apparently without any unfavorable reminder of his accident.

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Georgia Journal of Medicine and Surgery.

EDITED BY

St. J. B. GRAHAM, M. D. W. E. FITCH, M. D.

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All editorial communications should be addressed to St J. B. Graham, M. D., No. 6 West Liberty Street, Savannah, Ga.

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HALF-TONE ENGRAVINGS to illustrate accepted articles will be made free of charge, if proper drawings or negatives accompany the manuscript. Electrotypes of such cuts furnished at cost.

PHYSICIANS' WANTS, ETC.—A department will be devoted to the free publication of subscribers' wants, practices for sale, change of location, etc.

SECRETARIES OF MEDICAL SOCIETIES will do us a favor by keeping us informed of dates of meetings of same, etc

THE BABY'S DIET.

The problem of artificial feeding is one of growing importance, especially to the family physician and obstetrician, the latter of these is especially derelict in his duty if he fails to inform himself upon the great advances which have lately been made in this direction. The cause of much of the indigestion, inanition and marasmus seen during infancy is laid during the first few weeks of life, but the importance of starting the diet right from the very outset is not yet sufficiently appreciated. An attack of indigestion must be regarded as a serious misfortune for a child; the younger the child, the greater the misfortune. A single careless feeding may produce an acute indigestion which will be the starting point of a long series of digestive disturbances. A few weeks of improper feeding may so derange the digestive processes that the infant does not regain its normal digestive power during its first year.

The error is quite too common of looking upon the body as a machine, any derangement of which will be set right by simply removing the cause. The human body is not a lifeless machine, but a combination of living tissues, each of which has its own functions to perform. Stopping the original cause of disturbance does not, therefore, usually stop the symptoms. A child that has been improperly fed can rarely be set right at once by the administration of proper food. If the indigestion is due to bacterial action, or to a vegetable

ferment, it will probably continue for a certain time under the most favorable feeding, because the germ or the ferment remains to act upon everything that is introduced into the stomach. An intestinal catarrh, once begun, is *very* slow and difficult of cure, and will prolong the indigestion.

When the digestive secretions are impaired, or undergo any decided change, they do not at once recover themselves or adapt themselves to changed conditions even if those conditions are perfection itself. The nervous system, notably that portion which presides over the digestive functions, readily acquires habits and peculiarities of action which continue after the causes which generated them have been removed. The debility and anemia which quickly follow in the train of improper diet are felt by the digestive organs in common with the rest of the body and impair their action long after the cause is removed.

The younger the child, the less is its resisting power, and the more potent do these various factors become. There is no more difficult task than the remedying of an impaired digestion in a young infant. In no place is the old adage that an ounce of prevention is better than a pound of cure more true than in medicine ; in no place in medicine is it more true than in the management of early infancy.

Error is constantly being made in allowing new-born babies to have too much food, to have it at irregular intervals, and without proper preparation. One of the most common errors is the use of too strong milk mixtures. During the first two weeks, the baby should be fed every two hours by day and should not have more than two feedings between 10 p. m. and 7 a. m. With the beginning of regular feeding on the third day, the amount of each feeding should not be more than one ounce, which may be increased to two ounces by the fourteenth day. In exceptional cases two and one-half ounces may be given.

Even in the case of breast-fed babies, the doctor has an important duty to perform in giving rigid instructions regarding regularity of nursing, the duration of each feeding, and the management of the breasts. The importance of engendering right habits in the breast-fed infant is almost as great as in the case of the artificially fed. The well-being of the infant, as well as the well-being and comfort of the mother, depend greatly upon the habits formed during the first few weeks. Whether the baby be breast-fed or bottle-fed, the physician is derelict in his duty, if he neglects to start the diet right.

ADVANCES IN MEDICINE AND SURGERY DURING THE PAST CENTURY.

A century ago the science of medicine and surgery was in its swaddling clothes. There were men who practiced medicine in those days, as there were for ages before, but it is a serious question

whether these men, in their efforts to deal with disease, did not do more harm than good. The system of blood-letting, and the practice of giving enormous doses of poisonous medicines without understanding the diseases to be combated, were measures which were extremely taxing on the robust constitutions of our forefathers; and it is certain that many of them were sent to untimely graves by the overzealous treatment which was then in vogue.

The greatest strides which the past century witnessed in our special field were not in curative medicine, but in measures for the prevention of disease. At the beginning of the century the laws of sanitation were almost wholly unknown, and were universally disregarded. There were no adequate water works or sewage systems in cities, and garbage and filth was allowed to accumulate as long as it did not interfere with traffic. Food and water were in consequence polluted. The direct relation of filth to disease was not understood. In consequence of this condition disease was rampant, and epidemics had full headway. This has all been changed—the principles of personal and public hygiene are well understood, and are constantly being put into more active practice.

The advances in surgery have been marvelous. A hundred years ago anesthesia was unknown. Asepsis was not recognized. Instruments were crude, and surgical methods were barbarous. It is almost impossible to conceive how surgery could have been anything except a name. The surgery of to-day cannot be said to have descended from or to be in any way related to the old system. It is a new creation, and in its conservative practice is a priceless boon to mankind.

In the treatment of disease by purely medical methods, no such extraordinary improvements can be claimed. As regards the actual cure of most diseases we stand almost as helpless as our predecessors of a hundred years ago. Our results, however, are vastly superior to theirs, because of our reliance upon proper hygiene, nursing and diet, and adherence to the doctrine of non-interference except when remedies are positively indicated.

The brightest laurels of modern medicine are those attained by the great discoveries made in the etiology of disease, in bacteriology and in pathology. On these discoveries must be built our hopes for the future. Diagnosis is fast attaining perfection, and successful methods of treatment are being zealously sought for.

The latter part of the past century marked the beginning of a new epoch in medicine and surgery. The foundation has been well laid, and it is for our present generation to see that the superstructure is well begun.

Think of vaccination made applicable to general medical practice, made compulsory by law and universal by education, so that smallpox, once the greatest scourge of mankind, is almost exterminated; anesthetics discovered by Crawford W. Long, of Georgia, and introduced into surgery, so that operations can be done *without pain* and

the length of operation consequently prolonged so as to make possible manipulations formerly not dreamed of; the germ theory of disease worked over by Pasteur and Koch, and applied to medicine and especially to surgery by Lister, so that wounds can be treated *without danger of suppuration or gangrene*; the facts of immunity worked out by scores of active minds, culminating in the discovery of the *serum therapy* by Behring, and of the infinite number of minor contributions to hygiene and prophylaxis, the application of dressings, the hemostatic forceps, the various ligatures and sutures—who has time to think of them all?

EDITORS' TABLE.

The Maltine Company has, during its existence of more than 25 years, cosistently depended upon strictly ethical methods in building up its great business. It submits samples of its products to physicians, to enable them to satisfy themselves of their therapeutic value, issues clinical records made in the leading hospitals and by reputable physicians in private practice, and publishes dignified and effective advertisements in medical journals. All inquiries, requests for literature or samples from laymen are referred to local physicians.

Now the company has taken another step, wise and far-reaching, which will add still more to its prestige among the profession. It will, in future, not only refuse to supply the Maltine preparations to department stores, but will refuse to supply them to dealers who are known to sell them to department stores. This not only emphasizes the fact that the Maltine preparations are classed as standard ethical products, just as quinine, iodide of potassium, fluid extracts, etc., are, but will enable retail druggists to secure the legitimate profit which is clearly due them.

We trust that our readers will duly appreciate the importance of the Maltine Company's new policy and continue to accord it that support which its honorable and consistent methods so richly deserve.

If a few other reputable houses would do likewise, it would make many friends for them.

* *

New Orleans Polyclinic.—Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, particularly laboratory work. Fourteenth annual session opened November 12, 1900. For further information, address Dr. Isadore Dyer, Secretary, New Orleans Polyclinic, New Orleans, La.

* *

Prize Essay on the Dangers of Quackery.—The Colorado State Medical Society offers a prize of twenty-five dollars for the best es-

say, if deemed worthy of the prize, pointing out the dangers to public health and morals, especially to young persons, from quackery as promulgated by public advertisements.

The competition is open to all. Essays must be type-written in the English language, and submitted before May 15th, 1901. Each essay must be designated by a motto, and accompanied by a sealed envelope, bearing the same motto, and enclosing the name and address of the author. The essay receiving the prize will become the property of the Society for publication. Others will be returned on application. Essays should be sent to the Literature Committee, Room 315 McPhee Building, Denver, Colorado.

* *

Notice.—Sander & Sons' Eucalyptol.—Apply to Dr. Sander, Belle Plaine, Iowa, for gratis-supplied sample and literature on Sanders' Eucalyptol. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

* *

Dr. Daniel W. Marston has been appointed Visiting Surgeon to the Randall's Island Hospitals by the Department of Public Charities.

* *

Some Suggestions on the Manner of Using Protargol.—Having passed the experimental stage, it may now be safely asserted, on the ground of the remarkably extensive literature published, that protargol is one of the most important additions to the materia medica of recent years. Aside from its general use in the treatment of gonorrheal affections it has to a great extent displaced nitrate of silver in diseases of the eye, ear, nose and throat. To obtain uniformly good results, attention has been lately drawn to the importance of exercising proper care in making the solutions, a point which has been especially emphasized by Professor Neisser. A clear and satisfactory solution can be secured in any one of the following ways: stir the protargol powder into a thick and smooth paste with a little cold water, and then add the bulk of the fluid. This should be done in a glass or china vessel, using a glass rod; if in a mortar, the latter as well as the pestle should be slightly moistened with a few drops of glycerine. Protargol may also be readily dissolved by dusting the powder evenly upon the surface of the water and allowing the fluid to stand without stirring for about ten minutes. It is very essential that only *cold* water should be used in making the solutions, as with warm water the drug is to some extent decomposed and then becomes less active and may cause irritation; for the same reason the solutions should be preserved in dark colored yellow bottles. In acute gonorrhea the average strength of the solutions ranges from one to ten grains to the ounce; in chronic urethritis, up to thirty grains; in diseases of the eyes, ears, nose and throat, ten to sixty grains; as an application to wounds and ulcers, one to two per cent. solutions and five cent. ointments are in use. Unlike nitrate of sil-

ver, protargol does not stain the skin even in concentrated solution. The solutions commonly employed in gonorrhea also do not produce stains of the clothing, or if they do, only cause slight discoloration, which can be easily removed with warm soap water. The much stronger solutions of twenty to fifty per cent. sometimes leave behind brownish-yellow stains on the clothing; if recent, they can be removed with soda and ammonia; if old, by the action of peroxide of hydrogen in the presence of ammonia.

* *

The Meeting of the Medical Association of Georgia.—This may be a little early, but we want to keep the profession reminded that the next meeting of the Medical Association of Georgia will be held in Augusta on April 17th, 18th and 19th. We want to try to make it one of the largest and most interesting meetings in the history of the Association. We understand attempts will be made looking towards getting rid of quackery in Georgia.

Dr. St. J. B. Graham, Savannah, Ga., chairman committee on programme, urges all members who intend to read papers at this meeting, to send titles of papers as soon as possible.

NEW BOOKS.

FROM W. B. SAUNDERS & CO.

Obstetric and Gynecologic Nursing.—By E. P. Davis, A.M., M.D. Professor of Obstetrics in Jefferson Medical College and Philadelphia Polyclinic. 12mo, Volume of 402 Pages, Fully Illustrated. Philadelphia and London: W. B. Saunders & Co., 1901. Price, $1.75, net.

This volume is designed to furnish instruction as to the various duties of the obstetric and gynecologic nurse. Obstetric nursing demands some knowledge of natural pregnancy, and of the signs of accidents and diseases which may occur during pregnancy. It also requires knowledge and experience in the care of the patient during the labor and her complete recovery, with the needs of her child. The obstetric nurse must also know how to help patient and doctor in the accidents and complications of labor, and has an important part to play in caring for mother and child in the diseases which occasionally attack them during the puerperal period. Gynecologic nursing requires special instruction and training, and a thorough knowledge and drill in antisepsis are absolutely indispensable.

Part one is devoted to Obstetric Nursing. Here the author reviews, in a very practical, concise manner, the duties of the nurse in obstetric practice; just how she is expected to assist during the delivery; care of the child and mother after the third stage is completed; her duties during the lying-in period; her duties in obstetric

operation, sepsis and other complications of the puerperim, including disorders of infancy and development of the child.

Part two is devoted to the duties of the nurse in caring for gynecologic cases. The author briefly but concisely directs the nurse how to prepare patients for examination, the positions and care and rest of patients before and after gynecologic operation; the preparations necessary when peritoneal cavity is opened; the immediate preparation for operation; her duties after the operation in convalescence and recovery.

With an appendix on dietary, preparation of surgical supplies, hospital methods for the preparation of surgical dressings, sutures, etc., and general aseptic precautions, it is a very valuable work for the nurse, and ought to be in the possession of every nurse. We highly commend the book. Doctor, it would be a nice present to your nurse.

The American Year-Book of Medicine for 1901.—A Yearly Digest of Scientific Progress and Authoritative Opinion in all Branches of Medicine and Surgery, Drawn from Journals, Monographs and Text-Books of the Leading American and Foreign Authors and Investigators. Arranged with Critical Editorial Comments by Eminent American Specialists. In Two Volumes—Volume I, Including *General Medicine*, Octavo, 681 Pages, Illustrated; Volume II, *General Surgery*, Octavo, 610 Pages, Illustrated. Philadelphia and London: W. B. Saunders & Co. 1901. Per Volume: Cloth, $3.00, net; Half Morocco, $3.75, net.

The issue of the Year-Book for 1900 in two volumes met with such general approval from the profession that the publishers decided to follow the same plan with the Year-Book for 1901. This arrangement has a two-fold advantage. To the physician who uses the entire book, it offers an increased amount of matter in the most convenient form for easy consultation, and without any increase in price; while specialists and others who want either the medical or the surgical section alone, secure the complete consideration of their branch at a nominal sum, without the necessity of purchasing considerable material for which they have no special use.

The first volume (Medicine) contains about 600 pages—an ideal size for convenience of handling and reference, condensing, as it does, the practical results of the past year's progress in medicines brief, yet complete in every detail, practical and to the point. As a year-book it heads the *list* as the most useful of its class, and one the busy practitioner *must* have in order to keep abreast with recent advances.

The first subjects considered are "Typhoid Fever" and "Malarial Fever." The information contained in these subjects alone are worth the price of the book. Where special attention is directed to any part of the subject under consideration, the print is in bold-face

type. at first glance calling your attention to just what you are looking for.

The second volume is devoted exclusively to surgery and contains the gist of all that is new in this scientific field of research, and contains the authoritative opinion in all the branches of surgery extracted from journals, monographs and text-books of leading American and foreign authors and investigators.

This volume is a twin brother to the first, and, like it, contains all that is new and practical on this subject, condensing in about 600 pages the results of the past year's advances in surgical science; brief, yet thoroughly complete in every detail, and a very useful book in its class. Each volume is complete in itself, and the physician or surgeon who wants either the medical or surgical volume can receive the complete consideration of his special branch without the necessity of buying the other.

Each volume is paged separately and has its own index, which is the work of a skilled artist.

This is an invaluable work and contains a resume of all that is of any importance which has been transpired in either medical or surgical science during the year that has just closed. It is a valuable acquisition to any physician's library—not only for those who write and must therefore keep up, but also those who treat diseases and practice surgery, for everything new in both branches can be found in this work.

In closing, the reviewer cannot but be impressed with the character of the work as compared with the present numerous "Annuals" or "Year Books" published with the object of recording, in condensed form, the greater part of medical literature of the year. Yet, in most of them, the process of "boiling down" has been practiced without first sifting the useful from the useless, with the result that the busy physician has presented to him a mass, concentrated, it is true, but so varying in quality that the good can only be separated from the bad by a process as difficult as that needed for the utilization of the first crude material.

Mr. Saunders turns the volumes from his presses in good style, in fact gives them all the art in book-making for which he is pretty famous.

The Pathology and Treatment of Sexual Impotence.—By Victor G. Vecki, M.D. From the Author's Second German Edition. Revised and Rewritten. Philadelphia: W. B. Saunders & Co., 925 Walnut Street. 1899. Cloth. 283 pages. $2.00 net.

There are no books which it gives a reviewer more pleasure to write about than those which he has not been hurried in reviewing, but which has been read and reread until the work is an old and trusted friend. Such a one is the work we are tardily reviewing; a book we have learned to trust, which, by experience, we have found truthful, up to date and wholly satisfactory.

How many times in the year that this work has been on our shelves, upon reference to it we have found the subject treated satisfactory in all respects. Perhaps our admiration for the work may spoil our quality as critics and reviewers, but it cannot prevent us from telling our friends that they will search far, indeed, and in many languages, to find its equal. For the young practitioner it is a book nearly of necessity, and to them, as to all others, we advise its perusal.

FROM J. B. LIPPINCOTT & CO.

International Clinics.—A Quarterly of Clinical Lectures and Especially Prepared Articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pædiatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose and Throat, and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A.M., M D., Director of the Ayer Clinical Laboratory of the Pennsylvania Hospital; with the Collaboration of John B. Murphy, M.D., Chicago; A. D. Blackader, M.D, Montreal; H. C. Wood, M.D., Philadelphia; T. M. Rotch, M.D., Boston; E. Landolt, M.D., Paris; Thomas G. Morton, M.D., and Chas. H. Reed, M.D., of Philadelphia; with Regular Correspondents in Montreal, London, Paris, Leipsic and Vienna. Volume IV. Tenth Series 1901. Cloth, $2.00 per volume. J. B. Lippincott & Co., Philadelphia.

That this work is needed and appreciated by the profession is clearly proved by the great success of the publication during the last nine years of its existence. The work has been carefully prepared and has been crowned with meritorious success.

This quarterly makes unquestionably one of the most complete and most reliable reviews of the advances in scientific medical literature with special reference to its practical applications that has yet been published. The editor has selected the very best contributors—men who know their business in their different departments and who do it well and thoroughly. They are men of experience, reputation, and men whose opinions are respected.

One among the most interesting chapters is that entitled "Mosquitos and the Prophylaxis of Malaria," by Professor B. Grassi, of the University of Rome, who believes in the mosquito theory—of the transmission of malaria.

Part second is devoted to a symposium on "Genito-Urinary Diseases," beginning with Gonorrhœa, by A. Renault, M.D., of Paris. He is a believer in the old methods—copabia and cubeb mixture. Dr. James Pederson, of the Post-Graduate School and Hospital, New York City, describes the treatment of Urethretis in the Male in a very interesting and practical paper. Mercury, in the treatment of syphilis, is a subject handled by A. H. Ohman-Dumesnill, M.D.,

of St. Louis. Dr. A. Tournier, of Paris, tells you about the Complications of Syphiletic Chancre. Following this, Dr. A. V. Meigs writes about Cardiac and Pulmonary Lesions in Renal Complications.

"The Etiology and Morbid Anatomy of Various Diseases," is described in a monograph by H. W. Cattell, A.M., M.D., viz.: Acromegaly, Actiniomycosis, Addison's Disease, Aneurysm, Anthrax Appendicitis, Arterio-Sclerosis, Ascites, Asthma, Beriberi and Blood Diseases.

Bronchitis, Cancer of the Biliary Passages, Chlorosis, Cretinism, Dengue, Diphtheria, etc., are diseases to tuberculosis of the lungs. This is one of the most valuable chapters in the book to the general practitioner.

The publishers have added the names of many prominent physicians and surgeons to the corps of editors and made many new departures which will be appreciated by the profession.

The "International Clinics" are indispensable to those unable to keep up their knowledge and experience for want of post-graduate opportunities. This is the purpose which they are meant to serve and they do it well. Taking the volume as a whole, it is very creditable to the editors, the enterprising publishers get it out well bound, profusely illustrated, on good paper, and again have the profession under obligations to them, which can only be repaid by purchasing the volumes as they appear.

An Experimental Research into Surgery of the Respiratory System—An essay awarded the Nicholas-Senn Prize by the American Medical Association for 1898. By George W. Crile, A.M., M.D., Ph.D., Professor of the Principles of Surgery and Applied Anatomy in the Cleveland College of Physicians and Surgeons; formerly Professor in the Medical Department of the University of Wooster; Attending Surgeon to the St. Alexis and Cleveland Hospitals. 114 pages, cloth binding. Price, $2.50. Philadelphia, Pa. J. B. Lippincott Co.

When we consider the importance of this subject one is a little surprised that there has not been presented before this a thorough exposition of this important branch of surgical study.

The book before us is the most exhaustive work on The Surgery of the Respiratory System we have ever examined. The author has subjected to experiment hundreds of animals, obtaining graphic data of the performance of various surgical operations, keeping records of each experiment, including tracings descriptive of the animals' weight and autopsic findings. The book will be of special interest to nose and throat specialists, since the author goes into the surgical science of all operations in this speciality. The chapter on the mechanism of drowning is of much interest to physicians.

It is well bound, and a worthy companion of Dr. Crile's book, "An Experimental Research into Surgical Shock."

FROM F. A. DAVIS CO.

A Text-Book of Practical Obstetrics.—By Egbert H. Grandin, MD., Gynecologist to the Columbus Hospital; Consulting Gynecologist to the French Hospital; Late Consulting Obstetric and Obstetric Surgeon of the New York Maternity Hospital; Late Obstetrician of the New York Infant Asylum; Fellow of the American Gynecological Society, of the New York Academy of Medicine, of the New York Obstetrical Society, etc., with the collaboration of George W. Jarman, M.D., Gynecologist to the Cancer Hospital; Instructor in Gynecology in the Medical Department of the Columbia University; Late Obstetric Surgeon of the New York Maternity Hospital; Fellow of the American Gynecological Society, of the New York Academy of Medicine, of the New York Obstetrical Society, etc. Third Edition, Revised and Enlarged. Illustrated with Forty-two Full-Page Photographic Plates and One Hundred and Five Illustrations in the Text. $6\frac{1}{2}$x$9\frac{1}{2}$ inches. Pages xiv–511. Extra Cloth, $4.00, net; Sheep, $4.75, net. F. A. Davis Company, Publishers, 1914–16 Cherry Street, Philadelphia.

We have already had the pleasure of reviewing the first and second editions of this "Practical" Work on Obstetrics, and that it has been necessary so soon to publish the third edition is proof of the reception it has met at the hands of the medical profession. As in the first edition, the subject matter is divided into:

Part I—Pregnancy.

Part II—Labor.

Part III—Puerperal State.

Part IV—Obstetric Surgery.

The revision of this edition has been carefully made. A chapter has been added on "The Anatomy and Embryology of the Female Organs of Generation."

The authors make this chapter very concise, giving only such data of an anatomical and embryological nature as are essential to the exemplification of obstetric teaching. The work before us is practical in its teachings—a clinical guide to the practitioner.

The subject of Obstetric Surgery is written from a teaching basis, necessarily imbued with the personality of the authors, and is therefore not burdened with literature references from other authors.

The illustrations have been selected and prepared with special care in order to graphically depict the authors' ideas.

Symphysiotomy is a subject which some of the modern text-books on obstetrics do not go into as deeply as in the volume before us. The Galbiati knife and its uses are described, as well as the technique of the operation. It is a valuable help for the young practitioners, and to them and all others we advise its perusal. The press work, paper and illustrations are wonderfully good.

FROM E. B. TREAT & CO.

A Practical Treatise on Nervous Exhaustion, its Symptoms, Nature, Sequences and Treatment.—By George M. Beard, A. M., M. D. Edited with notes and additions by A. D. Rockwell, A. M., M. D. Fourth Editon, Enlarged. Cloth $2.00. E. B. Treat & Co.. 241–43, W. 23d St., New York. 1901.

Neurasthenia is now almost a household word, and equally with the term "Malaria" affords the physician a convenient cloak under which to hide a multitude of diagnostic errors. This class of nervous patients, many of them unintellectual phlegmatic, intolerably indolent, consider it fashionable and aristocratic to have "nervous prostration" and are highly pleased at such a diagnosis, rather than a disorder of the stomach, bowels or liver.

The contents of the book are divided into the following:

I.—An introduction to the study of neurasthenia.

II.—Symptoms of nervous exhaustion, to which the author devotes 81 pages.

III.—Nature and diagnosis of nervous exhaustion.

IV.—Prognosis and sequences of nervous exhaustion.

V.—Treatment and hygiene of nervous exhaustion.

VI.—Etiology and prognosis of nervous exhaustion.

The reader will readily see that the subject is thoroughly and completely covered. The book is written in a clear, practical, concise style, entertaining and not burdensome. [The Editor's notes are indicated by brackets and sundry foot notes.]

The author has designed this work to be exclusively practical and it is altogether one of the best works on this subject before the medical profession. We highly commend it to all who have to deal with this class of patients.

Messrs. E. B. Treat & Co. turn it from their presses in good style, neat binding and sell it for only $2.00.

PROGRESS
—OF—
MEDICAL SCIENCE.

THERAPEUTICS

UNDER THE MANAGEMENT OF
RALSTON LATTIMORE, M. D.,
SAVANNAH, GA

PHOSPHORUS POISONING.—A case of poisoning with some peculiar features is reported by Dr. Newey. (Lancet, 1900, No. 4021, page 875.) A man while drunk had taken a quantity of rat-killer containing phosphorus. He immediately complained of severe illness and of violent pain in the stomach, and was given salt and hot water, which produced vomiting and relieved him somewhat. He continued ill, however, and four days later became much worse, so that the doctor was sent for. The man was very thirsty, vomited constantly, and had severe pain in stomach and abdomen. The vomited matter proved on examination to consist wholly of altered blood of a very dark color. The stools were also dark and pitchy. In spite of treatment he continued to get worse, and died in a week's time.

The conditions found at the post-mortem were so peculiar that we publish them in detail: The whole of the neck in its entire circumference, back and sides, bore the appearance of having been stained in a deep solution of Prussian blue, the color being most intense and brilliant; it was not mottled, but uniformly stained. The arms and legs showed an icteric tinge; their superficial veins looked as though they had been injected with a solution of Prussian blue, and were most beautifully mapped out. The stomach contained $\frac{1}{2}$ pint of liquid blood, which was deeply colored blue; it showed softenings and ulcerations in patches, and was thickened in other parts. The whole of the intestines showed signs of an irritant poison; they were deeply pigmented with the blue color, and the contents were dark and pitchy. The transverse colon was intensely inflamed, and the fat of the great omentum showed bright extravasations of blood, and was most striking in appearance. The heart, liver and kidneys showed signs of commencing fatty degeneration. The lungs and the liver were deeply colored blue. The brain was rather anemic, soft, and almost diffluent in parts.—*Merck's Archives.*

NUMEROUS USES OF ALUM.—Alum, though a rather humble remedy, has nevertheless numerous therapeutic applications, according to Dr. Bunnell, (Med. Council, 1900. p. 379,) who thus enumerates the conditions in which it may be found useful. In sore throat it is used in a solution of 20 grn. to the ounce of water, either with a

swab or spray (as it is destructive to the teeth, the mouth should be washed out with an alkali). In hemorrhage, when it can be directly applied to the blood-vessels, alum is a remarkably efficient hemostatic. Night-sweats, or sweating of the hands or feet, are benefited by a wash of 2 grns. to the ounce of water. Hemoptisis is lessened by a fine spray of a solution of alum, 24 grn. to the ounce of water. In broncorrhea, or chronic bronchitis, chronic catarrh of the pharynx and larynx with excessive secretion, a solution of 16 grn. to the ounce of water may be used with good effect. It is very effective in nose-bleed, a small amount, finely powdered, being blown in with a powder blower, or applied on a piece of cotton wet with a solution of 24 grn. to the ounce of water. In uterine hemorrhage it may be used as an injection of the strength of 1 dr. to the pint. In hemorrhage after extraction of teeth, fill the cavity with a piece of cotton wet with a saturated solution, or covered with powdered alum. Conjunctivitis is benefited by a lotion of 2 grn. to the ounce of water, or in the form of alum curd, made by adding powdered alum to milk or white of an egg until a curd is formed, and this applied to the eye every two hours. This is also efficient in ecchymosis of the eyelid (or black eye). In granular conjunctivitis, the lid is lifted and a crystal of alum is passed lightly over its reddened surface. In gonorrheal ophthalmia it may be used in 6 grn. to the ounce of water, applied four times per day. In mercurial ptyalism a solution of 20 grn. to the ounce is used. Chilblains and pruritus vulvæ are improved by a wash of 16 grn. to the ounce. In diphtheria and follicular tonsillitis alum in the crystalline form is applied in the shape of a pencil. In ingrowing toenail, with granulations, a piece of absorbent cotton soaked in a solution of 30 grn. to the ounce of water should be inserted under the edge of the nail. Burnt alum is a good dressing for old sores, ulcers, swollen gums, and ulcerative stomatitis. In chronic inflammation of the throat, a gargle of 10 grn. to the ounce of water is effective. Leucorrhea is benefited by a douche, containing 4 dr. of alum to the pint of water, night and morning. Internally, alum is used for diabetes, gastralgia, dysentery, and consumption. In lead colic it is given with morphine. In membranous croup it is given in emetic doses, 36 to 60 grn., every fifteen minutes to bring up the membrane. For hoarseness, mix powdered alum and sugar in equal parts, and take a little on the tongue and let it slowly dissolve. In acute lead poisoning alum may be used as an antidote, as it is a soluble sulphate; it is also emetic. In the latter stage of whooping cough it can be given in from 2 to 5-grain doses in honey or molasses. In 30-grain doses every four hours it exerts a purgative influence. It is effective in immoderate secretions, as in the diarrhea of typhoid fever, night-sweats of exhausting diseases, passive bleeding from the lungs, stomach, kidneys, uterus, or bowels. It often relieves a cough that comes from a tickling in the throat. It is also useful used as a wash (weak) to strengthen the throat when it is in a relaxed condition.

Methylene Blue in Malaria.—Dr. M. Dunn, (Med. World, xviii, No. 12) of Louisiana, says that in the neighborhood where he resides filthy ponds and water-holes are found in great abundance, mosquitoes without number make life unberable, and malaria in its worst form reigns supreme. In the estivo-autumnal type of malaria, treatment with quinine is generally attended with fatal results. Since he has commenced using methylene blue (medicinal) he considers it a God send. He says: "There is no remedy yet discovered equal to methylene blue in cutting short malarial fever, and especially malarial hematuria; the fever leaves gradually in from seventeen to fifty hours." The author uses Merck's brand of methylene blue, and is not afraid to use it freely. As a rule he gives a hypodermic of morphine and atropine half an hour prior to the methylene. His favorite formula for the latter is:

Methylene Blue (Merck)	2 to 3 grn.
Quinine Sulphate	2 grn.
Iron Carbonate	1 grn.
Arsenous Acid	1-60 to 1-50 grn.

For one capsule. For acute fevers, one capsule every three hours; in chronic forms, malarial, toxemia, a capsule every four to six hours.

Methylene Blue as an Analgesic.—Klemperer (Epitome of British Med. Jour., 1900, No. 2080, p. 75) publishes his results obtained by the employment of methylene blue (medicinal) as an analgesic in 27 cases of sciatica. In 8 cases it failed entirely, in 6 cases the pains marvelously disappeared in five days, in the remaining 13 the sciatica resisted the treatment for several weeks, but the pains were less frequent and the patients were enabled to sleep at nights. Three to six capsules containing about 7 grn. were given daily. Slight gastric disturbances occurred, but they involved no serious inconvenience, and any pain during micturition was easily prevented by adding a little nutmeg to each dose. The writer has found the medicament very useful in tabes, neuralgia, and myalgia in diminishing the intensity of the pains. In these conditions it is best to commence with 4 grn., twice a day, and very gradually increase the dose up to 15 grn. or more. The drug must be absolutely pure, otherwise gastric, toxic, and diarrheal troubles will follow. It should be administered in well-made cachets, so as to avoid any discoloration of the mouth. The patient should be warned of the urinary change or color, and that some slight vesical spasm and dysuria may occur. The action of the methylene blue causes at first a numbness, passing gradually into analgesia; its action is rapid, but of not long duration. Hence it is necessary to continue the medication as long as any pain is felt. Local effects can also be obtained, but the disadvantage of its coloring power has not yet been overcome. It has been proposed also to use the methylene blue in subcutaneous injections, but at present there have been no experiences published. It is claimed that methylene blue in excessive doses does not cause the depression, etc., which usually results from increased amounts of the ordinary analgesics, and is worthy of extended use.

Dr. Hoff's Treatment of Pulmonary Tuberculosis.—Our yellow journals, which had been pining for some stirring sensation for quite some time, have discovered a new, marvelous, infallible treatment for pulmonary tuberculosis. Unfortunately, the treatment is neither new, nor marvelous, nor infallible, and Dr. Adolph Hoff, a modest assistant at Prof. Stoffella's clinic, little expected that when outlining his treatment of dispensary patients in the course of an ordinary article in a medical journal (Wien. med. Woch., 1900, Nos. 47, 48) he would be taken up by the sensation mongers and treated as one of the greatest discoverers and benefactors of mankind.

The principal combination administered is made as follows;

Arsenous Acid	1½ grn.
Potassium Carbonate	3 grn.
Cinnamic Acid	4½ grn.
Distilled Water	80 min.

Make a perfect solution by boiling; then add:

Extract Opium (Aqueous)	4⅓ grn.
Cognac	6¼ dr.
Distilled Water	6¼ dr.

Dissolve and filter. Of this mixture, 6 drops are given at noontime and in the evening after meals; the dose is gradually increased up to 24 drops.

Should the fever persist, as it does in a few instances, the following mixture is given:

Quinine Sulphate	8 grn.
Aromatic Sulphuric Acid	12 min.
Tinct. Quinoidine	40 min.
Syrup Cinnamon	5 dr.
Cinnamon Water	2 oz. and 3 dr.

Tablespoonful three times a day.

Where the cough is very annoying and troublesome, dionin is prescribed with good effect. The formula is as follows:

Dionin	3 to 5 grn.
Ammonium Chloride	5 to 8 grn.
Sodium Chloride	2½ dr.

Divide into ten powders. One powder once, twice and up to four times a day, according to indications.

In addition to this medicinal treatment, hydrotherapeutic measures play a very prominent part. Cold water is applied to the chest and back every night, and the applications are followed by a thorough friction; after the skin is dry, a sleeveless jacket, wrung out of cold water, is put on, and a dry shirt slipped on over it. The jacket is removed in the morning, as soon as the patient gets up; the chest is dried, the cold water applications, followed by friction, are repeated, and the patient then dresses.

As will be seen from the above, the treatment is a good commonsense one, but it does not contain a single drug or measure which has not been used before in the treatment of pulmonary tuberculosis.

INTERNAL MEDICINE AND NEUROLOGY.

UNDER THE CHARGE OF

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THE SELECTIVE INFLUENCE OF POISONS IN RELATION TO DISEASES OF THE NERVOUS SYSTEM.—By Dr. F. W. Mott, in Lancet, January 26, 1901. The author's article deals with the primary intoxications and degenerations of the nervous system which are occasioned directly or indirectly by some general toxic condition of the blood or lymph. In a great number of instances, particularly groups of neurones are especially affected by particular poisons. These poisons act by increasing or diminishing the excitability of the nervous elements. Whether a poison is exogenetic or autogenetic, it is the toxic state of the blood or lymph that causes the morbid nervous phenomena. Of the exogenetic poisons, one great group is of those substances used as intoxicants—alcohol, opium, haschisch, cocaine, tobacco and absinthe. The abuse of alcohol is the most widespread and potent cause of nervous and mental diseases. The various specific effects produced by the above-mentioned poisons are dealt with in detail. Poisons may be produced within the body (1) by the perverted action of the organs or tissues, and (2) by the action of micro-organisms upon the living fluids and tissues of the body. As belonging in the first class may be mentioned uræmia, cholæmia, uricacidæmia, acetonæmia, and the perverted state of the blood or lymph in myxœdema and Graves' disease. The spinal scleroses observed in pernicious anæmia are due, not to hæmolysis, but to some toxic agent absorbed into the portal blood from the alimentary canal. The best examples of the selective action of microbial toxines are afforded by rabies and tetanus; diphtheria, influenza and other affections may also be cited. Syphilis is a poison which is responsible for a large proportion of organic nervous diseases. It may attack the nervous system directly, or it may produce progressive degenerations (locomotor ataxia, general paralysis of the insane).

A SUGGESTED METHOD OF PREVENTING WATER-BORNE ENTERIC FEVER AMONGST ARMIES IN THE FIELD.—L. C. Parkes and S. Rideal, D. Sc., in N. Y. Med. Jour. The authors report the results of their experimental trials of acid sodium bisulphate as a destroyer of typhoid bacilli in drinking water. They conclude that water naturally infected with the virus of the disease never contains large numbers of typhoid bacilli, and that these organisms are not by any means resistant to acids or other weak disinfectants. Their experiments

show that in the case of such naturally infected waters, sodium bisulphate in the proportion of one gramme to the pint is an effective antiseptic after fifteen minutes' contact, even for waters containing 50,000 bacilli to the cubic centimetre. They recommend its employment in the form of five-grain tabloids, three of these being used to sterilize one pint of water. A box containing three or four hundred of these tabloids can easily be carried by each soldier, and would suffice for a campaign of three weeks. But instruction must be given as to their use, and especially as to the necessity of allowing all contaminated water to remain in contact with the dissolved tabloids for at least fifteen minutes before being consumed. The tabloids may also be used as thirst lozenges when water is scarce.

Considerations Touching the Pathology and Relations of Diabetes. By Dr. W. H. Dickinson, in Lancet, February 2, 1901. The author reviews the morbid anatomy of diabetes in the light of our present knowledge. The most frequent morbid appearance found in connection with diabetes is extravasation of blood in the perivascular canals of the brain, not limited to, or constant in, any one part, but scattered apparently at random around the deeper arteries and also the more minute vessels of the pia mater. These extravasations are the results of transudation and have no connection with the coma of diabetes. Such privascular hemorrhages indicate an abnormal condition of the cerebral circulation. Enlargement of the privascular canals also takes place, giving to certain districts of the white matter a cribriform appearance. Leucocytes, amorphous matter and blood crystals may be found in these canals. Dilatation of the central canal of the spinal cord occasionally occurs in diabetes. There is also sometimes to be observed a peculiar hyaline modification of the lateral parts of the gray horns. Next to the brain, the liver supplies an early step in the diabetic process. The diabetic liver is large, hard, red and congested. The vessels are full of blood and have been known to present coagulation both in the arteries and veins. Mention is also made of the consequential changes to be observed, such as cataract, pulmonary tuberculosis, etc.

Grief, anxiety and terror may all be so closely followed by diabetes that there is no room for doubt as to their having occasioned it. Heredity is a prominent cause, as also gout. The loss of the patellar reflex may be regarded as one of the most constant signs of the disease. The extravagant exit of phosphate of lime in some cases of diabetes has to do with the state of the nervous system in this disease. The peculiar dusky redness of the complexion, so often present in advanced cases, suggests a connection with the nervous system. Glycosuria in small amount accompanies insanity, not frequently, but often enough to imply a morbid relation between the two. From these facts the conclusion is reached that diabetes is not a "functional disease," and that in all probability its pathology is closely associated with that of disease of the nervous system.—*N. Y. Med. Jour.*

The Hæmorrhagic Diathesis in Typhoid Fever and Its Relationship to Purpuric Conditions in General.—By Dr. A. G. Nicholls and G. E. Learmouth, B. A., in Lancet, February 2, 1901. In the present communication the authors report a most extreme example of enteric fever with the hæmorrhagic diathesis. The case was that of a woman aged 21 years, and the first hæmorrhage (into the skin of the abdomen) was observed on the fourteenth day of the disease. Thirteen days later the patient had two intestinal hæmorrhages and multiple hæmorrhages over the trunk. The next day there was nosebleed and hæmorrhage from the lips and gums and into the conjunctivæ. These losses of blood continued and the patient died on the fortieth day of her illness. The temperature was never very high. The post-mortem examination showed the case to be one of typhoid fever, atypical in the particulars that the intestinal lesions were most marked in the large bowel, that the spleen was small, that there was a general hæmorrhagic diathesis, and that there was a mixed infection with the staphylococcus albus. One main factor of the extensive hæmorrhages was the fatty degeneration of the basement membranes of the capillaries, which was especially noticeable in the lungs and kidneys. The authors refer this fatty degeneration, not to any local action of bacteria, but to a condition of systemic intoxication and septicæmia. They have studied the literature of hæmorrhagic typhoid, and discuss its pathology, symptoms, prognosis and treatment. The cases fall into three groups: (1) primary typhoidal purpura; (2) purpura due to secondary bacterial invasion; and (3) cachectic purpura. The condition is generally very grave and the treatment is purely symptomatic. "Purpura hæmorrhagica" is to be looked at as a train of symptoms. In the light of our present knowledge, it would be better to speak of (1) an "essential" purpura, including morbus Werlhofi, purpura simplex, purpura urticans, etc.; (2) "symptomatic" purpura, including all those cases met with in the course of the infective fevers; (3) "cachectic" purpura, as seen in Bright's disease, pernicious anæmia; (4) "toxic" purpura, due to snake-bite, poisons, etc.; and (5) that form of purpura seen in disseminated sarcomatosis. The first two groups, and possibly the third, would fall under the head of "infectious" purpura.

The Treatment of Typhoid Fever.—By Dr. F. J. Smith. In the treatment of typhoid fever two principles are of overwhelming importance: these are (1) the examination (daily) of the stools; and (2) the appetite of the patient. 1. In the stools may be found (*a*) undigested milk or other food, showing that too much food is being given; (*b*) blood, which, if present in any quantity, calls for the administration of opium; (*c*) sloughs, the total bulk of which indicates the amount of ulceration; and (*d*) fæculent *debris*, the desirable constituent of the stools. 2. The appetite of the patient should be, within very wide limits, the sole arbiter of his diet, provided vomiting, hæmorrhage, or distension are all absent. The temperature is entirely

ignored. Where the appetite is good a wide range of dietary is allowed; where there is no appetite, the best food is plain cold water. The author has kept patients for days on nothing but water, with the best results. On the first indication of nausea after food, resort should be had to the plain water diet for twelve hours. Tympanites is an ominous complication and most difficult to treat. The author gives two drachms of sulphate of sodium every two hours until the bowels are acting freely. Constipation should never be allowed to persist. Excessive diarrhœa points either to too much food or to extensive ulceration of the colon. The occurrence of hæmorrhage calls for starvation and opium. Alcohol is unnecessary for the treatment of typhoid fever. The author believes that anti-inoculation is destined to be the universal method of treatment and prophylaxis in typhoid fever.—*N. Y. Med. Jour.*

The Complications of Gastric Ulcer and their Treatment.—By A. W. Mayo Robson, F. R. C. S., in British Medical Journal, February 2, 1901. In this article the author deals with some of the simple diseases of the stomach associated with ulceration, which are capable of relief or cure by surgical means. He classifies the various forms of gastric ulcer as follows: I. Erosions; *a.* simple erosions; *b.* exulceratio simplex, of Dieulafoy; this form of ulceration may give rise to severe hæmorrhage, which may rapidly prove fatal unless arrested by treatment. II. Simple ulcer; *a.* acute round ulcer, most often found in chlorotic young women; *b.* chronic ulcer, the form which most frequently gives rise to complications. After discussing the questions of symptoms, diagnosis and the advisability of exploratory operations, the author states that the treatment of gastric ulcer is at first essentially medical, and if properly carried out and for a sufficient length of time, is usually completely successful. Where surgical intervention becomes necessary, gastro-enterostomy, of all operations, is the one to rely on. The author prefers the posterior operation, the junction of the stomach and first part of the jejunum being effected by two continuous sutures around a decalcified bone bobbin. His last twenty cases have all recovered without pain or any drawback. Perforation is one of the most serious complications, and occurs in about fifteen per cent. of all cases of ulcer of the stomach. Doubtless many perforations are recovered from, if the accident happens when the stomach is empty. Statistics clearly prove that operation for perforation of gastric ulcer, if undertaken within a few hours of the accident, is very hopeful: but that death occurs in more than half the cases when operated on after twenty-four hours. Hæmorrhage occurs in eighty per cent. of all cases of gastric ulcer; surgical treatment should be adopted in recurring acute, as well as chronic, hæmorrhage. Cicatrical contraction of the pylorus is the complication of gastric ulcer which most frequently calls for surgical treatment; where active ulceration is going on, gastro-enterostomy is the best operation. In cases of hour-glass contraction of the

stomach, the operation of gastroplasty has given excellent results. The adhesions formed in cases of perigastritis complicating gastric ulcer often call for surgical treatment; this operation the author terms "gastrolysis."—*N. Y. Med. Jour.*

The Value of Blood Examination for Diagnostic Purposes.—Brandeis (Jour. Am. Med. Assoc., Nov. 24, 1900) believes that blood examinations are not carried out as systematically as they should be, considering the valuable aid which they render in diagnosis, differential diagnosis and prognosis. As a diagnostic aid, he mentions particularly the special changes met with in chlorosis, secondary anemia, pernicious anemia, leukemia—myclogenous and lymphatic—anemia infantum, pseudoleukemia, malaria, relapsing fever and filariosis. The diseases in which blood examinations are an important aid in differential diagnosis are, chlorosis from secondary anemia, and pernicious anemia, pernicious anemia from the anemia of malignant disease, leukemia from Hodgkins disease, leukemia from tumors of spleen and kidneys and from tubercular, syphilitic or malignant adenitis, syphilitic from tubercular or malignant disease, typhoid fever from malaria, paroxysmal hemoglobinuria from malaria, pnemonia from malaria, malignant liver disease from other liver diseases, puerperal sepsis from puerperal mania, renal or cardiac from bronchial asthma, hysteria and neurasthenia from many of the diseases which they simulate, gastric ulcer from gastric cancer, appendicitis from typhoid fever, intestinal, biliary or renal colic or floating kidney, peritonitis from tubercular peritonitis, malignant disease of liver from catarrhal jaundice, perinephritic abscess from cyst of kidney, pneumonia from typhoid fever, pyemia or septicemia from typhoid, meningitis from typhoid fever, meningitis from brain tumor, lead encephalopathy, diabetic coma, sunstroke, narcotic or alcoholic intoxication (Cabot), pneumonia from uncomplicated grippe, scarlatina from measles, empyema and pneumonia from serous pleurisy, suppurative from tuberculous processes, osteomyelitis from neuralgia or "growing pains," and purulent from catarrhal otitis media. As an aid in prognosis, he cites its value in pneumonia, diphtheria, chlorisis, anemia following hemorrhage, pernicious anemia, scarlatina and scarlatinal nephritis, appendicitis, septicemia and pyemia, malignant disease and phthisis.—*Int. Med. Mag.*

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THE ADVANTAGES OF CIRCUMCISION.—Jonathan Hutchinson, F. R. S. (Med. Rev., Nov. 1900), gives as the first advantage that of cleanliness. He calls attention to one fact, that while in adults the parts can be fairly cleansed by withdrawal of the prepuce, such repeated practice in childhood might result in the acquiring of vicious habits, to say nothing of the risk of producing paraphimosis. The writer points out that in middle life the possession of a prepuce is a source of constant annoyance, seborrhea, balanitis and herpes being very common affections. But the argument most strongly advanced is that circumcision tends to reduce the prevalence of syphilis. Statistics collected many years ago by the writer as to gonorrhea and syphilis in Jews, proved that while the former malady was as common among them as amongst Christians, syphilis was much less frequent. Hutchinson considers that no other measure for the prevention of syphilis which has ever been proposed is as efficient as circumcision, for the reason that the sub-preputial fold constitutes an eminently suitable soil for the propagation of any virus brought in contact with it.—*Int. Med. Mag.*

OBSERVATIONS IN THE TREATMENT OF ACUTE GONORRHEA.—Von L. Crick (Polyclin., Feb., 1900) gives an account of 17 cases treated with injections of protargol, according to the method of Neisser. Most of the cases complained greatly of the burning in the urethra produced by the sting and also of the difficulty in holding the solution in the urethra for so long a time. In closing, the writer states his belief to be that protargol does not destroy the gonococci any quicker or cure the disease more rapidly than other methods employed.

THE TREATMENT OF GONORRHEA IN THE MUNICH MILITARY HOSPITAL.—Wurdinger (München. Med. Woch., 1889, No. 31) finds that after 16 years' experience in this hospital, the new so-called specific treatment of gonorrhea possesses no advantages over the old hygienic and dietetic treatment with the use of astringent injections after the

subsidence of the acute symptoms. He finds that the disease is not in any way shortened by the use of these new specifics, 45 days being required in most cases to bring about a cure.—*Int. Med. Mag.*

A Case of Gonorrhea Complicated with Rheumatism and Disturbances of the Nervous System.—Kucharzewski (Progres. Med., Jan. 27, 1900) reports the case of a young man, 22 years of age, who, during an attack of gonorrhea, presented the following rare complications: In succession there developed a gonorrheal rheumatism of the knee and wrist and a light abortive polyneuritis in the lumbar region, pain in the chest, hyperesthesia of the lower extremities and increased patellar reflexes. No cause could be found to account for these conditions save the existing gonorrhea. This idea is substantiated by the fact that the rheumatism and nervous disorders ceased with the cure of the gonorrhea.—*Int. Med. Mag.*

Complications of Gonorrhea Affecting the Heart.—Thayen and Lazear [Jour. Exper. Med., 1899] report two cases of gonorrheal heart affection. In the first case warty endocarditis of the mitral valve existed. The second case was that of a young man who had contracted gonorrhea six weeks prior to admission to hospital. Examination showed a systolic murmur at the aorta, and lengthening of the first sound at the apex; hypertrophy of the liver and spleen, with hydrarthrosis of the left knee. The urine showed the presence of pus, albumin, blood and cylindrical casts. The patient died of uremia. *Post-mortem* examination showed hemorrhagic nephritis, congestion of the liver and spleen, considerable pericardial effusion and endocarditis of the tricuspid. In the blood and in the exudate in the heart, gonococci were found in abundance.—*Int. Med. Mag.*

Proctorrhaphy: The Suspension of the Rectum for the Cure of Intractable Prolapse and Inversion of that Organ.—Noble [Am. Gyn. and Obstet. Jour., Dec., 1900] reports 2 cases of obstinate prolapse and inversion of the rectum treated by entering the peritoneal cavity through the left rectus muscle, slightly below the level of the promontory of the sacrum, and attaching the rectum to the abdominal wall by 3 or more fine silk sutures. Traction is first made upon the bowel until the inversion is corrected, and its attachment then made under slight tension. The sutures include a portion of the rectus muscle and pass under the anterior longitudinal band of the rectum. The abdominal wall is then completely united by tier sutures. The first patient was a married woman of 35, and had been afflicted 5 years. Apart from some tendency to constipation there has been no recurrence, although over 18 months have passed since the operation. The second patient was a girl of 19, who had suffered from rectal prolapse for 3 years. Seven months after the operation the patient reported some tendency to recurrence when at stool. The operator believes, however, that with care to avoid constipation and straining, this patient will be permanently cured.

The Surgical Treatment of Primary Renal Tuberculosis, with a Consideration of the Immediate and Remote Results after Operation. Ramsey [Ann. of Surg., Oct., 1900], from a study of 307 cases of renal tuberculosis submitted to some form of operative treatment, considers the operation of nephrectomy or nephro-ureterectomy to be the most desirable operation for primary renal tuberculosis. Nephrotomy is reserved as a palliative measure to be used when the patient seems unable to endure the more radical operation. Nephrotomy is rarely, if ever, curative, but may tide the patient over until sufficient strength is gained to enable a more radical operation to be performed. Nephrectomy or nephro-ureterectomy, including at times a partial resection of the bladder, should be followed by a lasting cure in 55.5 of the cases. It is contraindicated in cases of disease of the other kidney or of tubercular foci in other organs. Tuberculosis of the bladder is not a contraindication, however, as it will probably heal later, and a small tubercular focus in the lungs is not always a contraindication. To avoid a persistent fistula, it is desirable to remove the diseased ureter, together with the kidney. To avoid hemorrhage, the ligature should always be employed instead of the clamp to control the renal vessels and it should be remembered that accessory renal arteries occasionally enter near the poles of the kidney. The danger of incomplete removal of diseased tissue contraindicates attempts to resect tuberculous foci in the kidney. Tuberculosis of the kidney may be classed as a semi-malignant inflammation—and always requires surgical intervention for its effectual treatment.

Treatment of Inoperable Malignant Disease.—Czerny [Therap. d. Segenwart., 1900, p. 202; Med. Rev., Oct., 1900] employs palliative operations, such as gastroenterostomy, entero-anastomosis, colostromy, gastrostomy, etc., or, when practicable, caustics in the treatment of malignant growths which give no prospect of cure by a radical operation. Chlorid of zinc he finds the most useful caustic. Superficial ulcers are first scraped with a sharp spoon and the caustic applied in the form of Canquoin's paste, stiffened with zinc oxid or wrapped in gauze bags. For deep ulcers a plugging with strips of gauze soaked in 20 to 80% of a watery solution of zinc chlorid is used. Carcinomas of the cervix uteri are scraped thoroughly, and when bleeding has ceased—often this does not occur until the next day—the zinc chlorid gauze is applied. A piece of silk thread is tied to the gauze, the vagina dried with alcohol, lubricated with oil and plugged with sterile gauze soaked in a 5% solution of sodium bicarbonate. After 6 to 24 hours the gauze is removed and the vagina irrigated with alkaline solution. Pain after the application may persist for 1 or 2 hours and necessitates an injection of morphin. The slough separates in 6 to 20 days. Great care is necessary in the case of malignant disease about the face or throat, death having resulted from the cauterization of the esophagus by the zinc chlorid. Com

presses of formalin in 10 to 30% solution are also at times useful. The use of zinc chlorid often leads to amelioration of the symptoms and at times seems to be followed by a permanent cure.

Transplantation of the Patella into the Tibia.—N. Senn, in the Philadelphia Medical Journal of October 27, 1900, has an account of the restoration of the tibia by transplantation of the patella. He says that repair of bone in man by transplantation from the lower animals is useless. Experimental research has also established the fact that transplantation of bone from one animal to another is negative. Bone may be transplanted from one human being to another.

The patient in whom the patella was transplanted was a boy 11 years of age. He was taken ill July 20, 1893, with fever and a rapidly increasing swelling involving the upper part of the leg and the left knee-joint. A large abscess formed below the joint. The patient presented the symptoms of progressive sepsis. The swelling involved the entire leg. A diagnosis of diffuse osteomyelitis of the tibia, complicated by suppurative inflammation of the knee-joint, was made. The shaft of the tibia was removed by free incision and the joint drained. This limited the progress of the infection, but suppuration continued for weeks. Owing to the absence of the shaft of the tibia, the upper end of the bone was gradually drawn upward. An attempt was made to restore the continuity of the tibia by transplanting the tibia of a young rabbit. The operation was a complete failure. The knee-joint in the meantime had become ankylosed, and it was decided to utilize the patella, which had become functionally useless, in restoring continuity of the bone. The patella and its ligament, with the overlying skin, were included in a horseshoe-shaped incision, with the concavity directed downward, and the flap, including the patella, was transplanted into the gap between the two fragments in such manner that the upper border of the patella was brought in contact with the lower fragment. The patella was not long enough to span the gap, and the upper border of the patella was perforated with a drill and the lower fragment impacted into it. Bony union was obtained between the patella and the lower fragment.

A few months later the patella was exposed by a vertical incision, divided obliquely, and the upper fragment was brought in contact with the upper end of the tibia. The two fragments of patella were then united with two strong catgut sutures, and the external incision sutured without making any provision for drainage. A false joint developed between the united surfaces of the patella, which was corrected by a later operation. A number of weeks later an *x*-ray demonstrated bony union between the patella and tibial fragments. The patient has now a useful limb and walks with a cane.—*Medicine.*

OBSTETRICS AND GYNÆCOLOGY.

UNDER THE CHARGE OF

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Full-Term Ectopic Gestation.—At the November meeting of the New York Obstetrical Society, Dr. E. B. Cragin presented a patient upon whom operation had been performed for Full-Term Ectopic Gestation, the child being alive, in perfect condition, and presented with the mother, before the Society. The patient had been admitted to the Sloane Maternity, giving the following history: Aged 33, German, married eight years; had had two miscarriages, one at six, the other at four months; menstruation had been regular, no history of endometritis or pelvic trouble. Last regular menstruation in January, 1900. In February she flowed for two weeks; in March she had a severe abdominal pain which confined her to her bed one week. Life was felt in June. On admission, pulse was 120, abdominal examination negative due to tympanites and rigidity of abdominal walls. Vaginal examination showed the vertex low down in posterior cul-de-sac, almost on the perineum. High up behind the symphisis the finger could just reach the posterior lip of the cervix but could not enter the cervical canal. As delivery per vaginam seemed impossible, it was determined to enter the abdomen. It was then found that the case was one of full-term ectopic gestation, within the folds of the left broad ligament, pushing the uterus up against the anterior abdominal wall, and dissecting the peritoneum from the posterior wall of the uterus. As a result of forty-eight hours of spurious labor, the ectopic sac was found ruptured and the intestines covered with fresh fibrin, stained with meconium. The point of rupture was quickly dilated with the finger and the living child extracted. The placenta was chiefly attached to the left broad ligament, and it was found that the maternal vessels supplying the area could be ligated. The uterus was so incorporated with the sac that it was decided to remove it, the sac and placenta en masse. Convalescence was smooth. The baby was kept in an incubator one week, then for one week in cotton, and since then it has been out of cotton. At birth it weighed five pounds. Dr. Cragin drew attention to the fact that the visible ectopic fetus was

worth saving, and with certain limitations, attempts to save the child do not seriously increase the mortality to the mother. He believes that at present in the majority of cases, the placenta is so attached that it is safer not to remove it at the primary operation, but that occasionally, as here, the attachment will be such that the maternal blood supply can be ligated and the placenta safely removed.—*Annals of Gyn. and Ped.*, January. E. N. L.

Cystic Kidney.—Dr. E. W. Cushing reports, in partial detail, three unusual cases of Cystic Kidney, with illustrations of two:

Case 1. A woman, aged thirty-five, was sent to the hospital with a diagnosis of chronic inflammation of the gall bladder, or a possible appendicitis. She had had four attacks of pain in the right side, in the region of the gall bladder. There was no history of gall stones being found. Pain, severe and paroxymal, lasted for several hours during each attack, the last one six hours. On examination a mass was found on the right side under the liver palpable in the loin; it seemed to be in the region of the kidney. Upon opening the abdomen to the right of the right rectus muscle, a tumor, cystic in character, the size of two fists, was found lying behind the posterior layer of the parietal peritoneum. Gall bladder normal. The peritoneum over the site of the tumor was opened, a large tumor enucleated, great care being taken not to rupture it. On the lower surface of the tumor a cord was found closely resembling a blood vessel, recognized as the ureter; this was tied off in two places and cut between. The enucleated tumor when brought outside the wound exposed the hilum containing the vessels. These were sewed off carefully with shoemakers' stitches, using a blunt aneurism needle. After cutting the tumor away the mouths of the venal vessels were tied again with catgut and the incision into the peritoneum united with catgut sutures. Patient made a good recovery. The tumor proved to be a kidney consisting of an enormously dilated pelvis, on which mass was found posteriorly a thin layer of venal tissue. The progress of dilatation turned the kidney upon itself so that the posterior portion pouched forwards and inwards, the ureter being obliterated.

Case 2. A woman, aged 25, gave evidence, upon examination, of a cyst the size of a child's head, in the median line, but seemingly having its attachment on the left side. Upon removal it proved to be an elongated mass of venal tissue, the ureter being pervious for about two inches from the kidney. This patient gave a history of pain for two years previous to operation.

Case 3. Gave evidence of a large abdominal tumor on examination, resembling in shape an ovarian tumor, although nothing was felt to indicate its being connected with any of the abdominal organs. Upon operation, the tumor was found to be behind the parietal peritoneum, which latter upon incision showed a diseased kidney, invaded by a vast number of cysts, the natural secretion of

the kidney not being impaired. This kidney was removed, although the opposite kidney showed a similar condition.—*Annals Gyn. and Ped.*, December. E. N. L.

Insanity in Women Associated with Pelvic Disease.—After briefly reviewing the current literature on the subject, Dr. W. O. Henry, of Omaha, before the Western Surgical and Gynecological Association, recorded sixteen cases from his own experience, of which ten were cured mentally and physically, three were improved, two unimproved and one died. The following deductions were drawn:

1. Many patients operated upon but not cured, had failed of relief either because attention to the local disease was not given early enough or was not sufficiently radical.

2. Every insane woman should be given the benefit of a thorough and painstaking pelvic examination, and all pelvic disturbance quickly cured as an essential element in permanent restoration of the mind.

3. In some cases, when lacerations had been repaired and endometritis cured, there still remained enough reflex trouble from the uterus and ovaries, not perceptible until their removal, to continue the mental disturbance and demand their entire removal.

4. The general practitioner, as well as the laity, should be more full alive to the connection between pelvic and mental diseases in women.

Sponges, Ligatures, and other Foreign Bodies in the Peritoneum. Carl Beck, in the Medical Record for November, 1900, says that sponges, compresses, and other large foreign bodies are sometimes left in the peritoneal cavity and make their way outward in a miraculous manner. Sometimes they make their way into the bowel and pass with the intestinal contents with comparatively little disturbance. Foreign bodies will either become absorbed, encysted, or enter the cavities of the intestines or uterus. Foreign bodies produce local vascular peritoneal adhesions, the contraction of which gradually pushes the body into the intestine. In one of the writer's cases a large gauze sponge was removed from an abscess in the abdominal wall, and in another case one passed by the rectum.

Sponges are not left in the abdominal cavity purposely, but ligatures are; silk is usually unabsorbable, but in some cases it may disappear. It is possible that, like gauze sponges, ligatures may also work their way into the intestine and thus be discharged without the knowledge of the patient. This may have been the case where the ligatures are said to have been absorbed. For this reason absorbable material should be used as much as possible, and sutures should be interrupted. If the suture does excite suppuration, it is much more difficult to get rid of a continuous suture than an interrupted one, because of the length of thread. Where symptoms rise from a buried suture, a way for the thread to make its way outward should be opened. In some cases absorbable sutures may act like foreign bodies.

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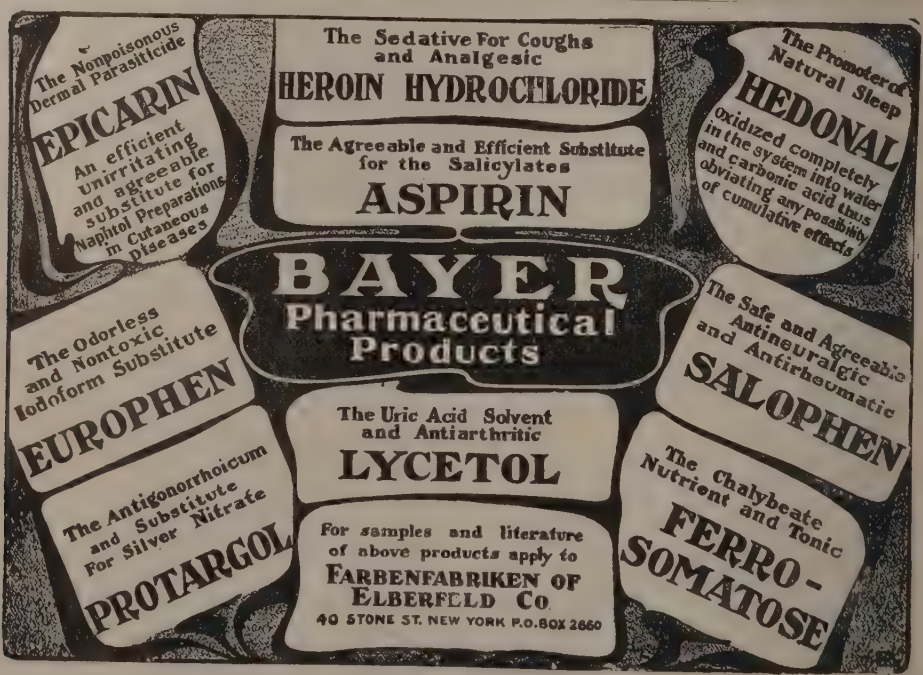
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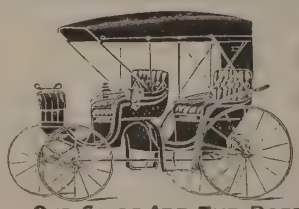

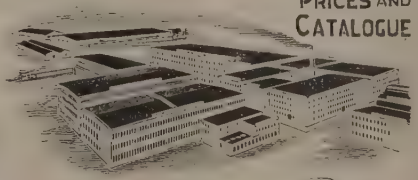

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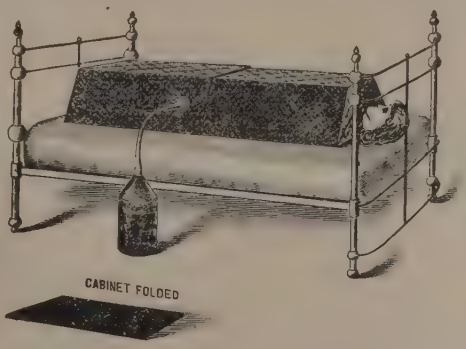

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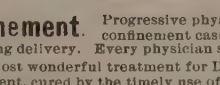

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